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REAUTHORIZATION OF THE NATIONAL INSTITUTE ON DRUG ABUSE AND THE NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM, 1984

HEARING

BEFORE THE

SUBCOMMITTEE ON
ALCOHOLISM AND DRUG ABUSE

OF THE

COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

ON

THE PROPOSED REAUTHORIZATION OF THE NATIONAL INSTITUTE ON DRUG ABUSE AND THE NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

MAY 1, 1984

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REAUTHORIZATION OF THE NATIONAL INSTITUTE ON DRUG ABUSE AND THE NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM, 1984

TUESDAY, MAY 1, 1984

U.S. SENATE,
SUBCOMMITTEE ON ALCOHOLISM AND DRUG ABUSE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:08 p.m., in room SD-430, Dirksen Senate Office Building, Senator Paula Hawkins (chairman of the subcommittee) presiding.

Present: Senator Hawkins.

OPENING STATEMENT OF SENATOR HAWKINS

Senator HAWKINS. Good afternoon. This hearing will come to order.

Today we will look into the reauthorization of the National Institute on Drug Abuse, commonly called NIDA, and the National Institute on Alcohol Abuse and Alcoholism; that is, NIAAA.

This would be a fairly routine hearing, except that the NIDA and NIAAA reauthorization bill which I have prepared and which I understand is going to be cosponsored by Senators Hatch and Kennedy, contains an exceptional first. For the first time, money is proposed to be set aside by the Institutions to study the prevention and treatment of alcohol abuse, alcoholism, and substance abuse among women.

Recent figures show alarming trends among women. The percentage of female members of Alcoholics Anonymous has risen from 26 percent in 1968 to 31 percent in 1980. Of the 10 million alcoholics in the United States today, up to one-half may be women; 68 percent of all psychoactive drugs are prescribed to women, a figure which indicates women are more prone to cross-addiction; that is, mixing alcohol with pills. To me, these are alarming figures, but perhaps they should not come as too much of a surprise because women have made great strides in the last 15 to 20 years entering the work force. We are breaking barriers, rising to those coveted, high-pressure jobs which up to now have been occupied only by men.

But the pressure at work is not the only pressure women face. After all, it is one thing to enter or reenter the workplace by choice, but many women do not have that choice. Consider the dis-

placed homemaker, divorced, or widowed after years of marriage with children still to raise, faced with loneliness, anger, betrayal, forced to reenter the job market, and competing with women much younger than she.

Recovering alcoholics are told to look out for four dangers; they are grouped together into the anagram HALT, four danger adjectives: hungry, angry, lonely, and tired. How many of these could apply to the typical displaced homemaker after only a few months?

Even if a woman realizes she has a problem, she may not be able to receive help. There are 5,577 treatment programs across the country, and of these there are only 375 women's treatment centers.

Many experts believe that women have needs which are not being met by the existing treatment system, a system which was really constructed to meet male needs. Most treatment programs do not provide child care or adequate alternatives for women who are entering treatment. There are fewer employee assistance programs in female-intensive industries.

Research on women with alcohol and other drug dependencies has been sorely neglected. An expert assertion made 15 years ago still holds true that studies on alcoholism tend to either ignore women entirely or to simply assure that alcoholism is the same regardless of the sex of the alcoholic.

The NIDA and NIAAA reauthorization bill would ask the directors of these organizations to carry out a program of research, investigation, experiments, and studies with an eye toward cataloging and finding ways to prevent and treat the alcoholism and drug-abuse problems that exist among homemakers; single women; single, divorced, and widowed mothers; displaced homemakers; women over 65; and pregnant women.

Another important aspect of this legislation is its request in regard to education. I recently held a hearing which looked into the role of the media in drug abuse prevention and education, and during that hearing we came to realize the vital role the media plays in shaping our children's opinions about drugs and alcohol.

My reauthorization legislation directs the Institutes to enter into contracts with television networks and/or producers to create and promote stimulating, informative, cost-effective commercials. These public-service announcements, shown on prime time, would fight drug and alcohol abuse through prevention.

For the money expended for these organizations, NIDA and NIAAA perform invaluable services. They provide leadership, policy, and goals in our efforts to discover the causes and cures of alcohol abuse, alcoholism and drug abuse.

They are the leaders in the various fields of research in these areas and are working to inform the public about the dangers associated with drugs and alcohol. They also make sure that those involved in prevention and treatment of these troublesome problems are informed and effective in their work. We thank NIDA and NIAAA for the work they have done thus far.

We have with us this afternoon the Director of NIDA, Dr. William Pollin, and the Director of NIAAA, Dr. Robert Niven. We also have with us Mr. Thomas B. Kirkpatrick, Jr. He is president of the National Association of State Alcohol and Drug Abuse Directors;

Dr. Sheila Blume, a member of the board of directors of the National Council on Alcoholism; and Linda Pasternak, the president-elect of the National Association of Alcoholism Treatment Programs. We welcome all of you and thank you for participating in this hearing, this afternoon, and are looking forward to your testimony.

I would now like a statement from you, Dr. Pollin.

STATEMENT OF WILLIAM POLLIN, M.D., DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION; AND ROBERT G. NIVEN, DIRECTOR, NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Dr. POLLIN. Thank you very much, Madam Chairman. I appreciate the invitation to appear before the committee today to discuss reauthorization of NIDA's research program. With your permission, I would like to summarize the statement and have it inserted in the record.

Senator HAWKINS. Surely.

Dr. POLLIN. Before getting to that summary, let me say, however, Senator Hawkins, that those of us who work in the field of drug abuse are very appreciative of the special, important, and effective focus that you have given personally to this issue. We are aware of and value that support.

Senator HAWKINS. Thank you.

Dr. POLLIN. The President's fiscal year 1985 budget funds NIDA's research activities at $63.5 million, an increase of $9 million, or 16 percent, above fiscal year 1984. I think I can best describe NIDA's programs by first summarizing our understanding of the national trends and dramatic changes that have taken place in the level of drug use in this country and then going on to speak about some of the major activities of NIDA in the field of prevention and research.

With your permission, I would like to use some charts that we have brought in. Mr. Egertson will help me in this. The major points that I would like to make in connection with these charts, Madam Chairman, are the following.

First, for a period of two decades from the late fifties through the late seventies, as shown by the green line, which in this case documents the extent of lifetime prevalence in young adults for marijuana—and this just typifies the larger problem—this country saw a dramatic, a tragic, a unique epidemic increase in the level of drug use throughout our population, but especially by young people and young adults—levels of increase twentyfold to thirtyfold, usually known only with regard to infectious disease epidemics.

That continuing increase peaked and began to level off in the late seventies and has been coming down since. And though we have made progress, I call your attention to the fact that the progress we have made thus far represents a recovery of only slight dimensions compared to what we lost in those earlier two decades.

A second point that I would like to make using this chart is that for the initial part of those two decades, the availability of drugs,

which is shown by the yellow-dashed line, very closely paralleled the increase in the use of drugs.

However, though availability has remained very high in recent years, the decreases that I will shortly spell out in somewhat more detail have occurred not so much because of reduction in supply, but because of changes in attitudes about drug use and in the perceptions of the health consequences of drug use.

This shows again that availability, as reported by high school seniors, one of the highest using age groups, has remained essentially constant throughout this period from 1975.

Despite this high availability of drugs, if we look at the level of daily use of marijuana by high school seniors, a level that is truly dangerous in terms of consequences, we see that after peaking at 11 percent in 1978, it has come down nearly 50 percent, so that in 1983 we are down to 5.5 percent.

This decrease in the number of users of drugs is not limited to marijuana. We see on this chart that the same is true with regard to cocaine. I should point out here that the fact that there is a decrease in the total number of individuals in the country using a given drug is in no way inconsistent with the fact that our drug problem remains a very, very serious one and, in some respects, continues actually to worsen.

On the one hand, for example, we have seen that we have come down from roughly 4.5 to 4 million current users of cocaine. But among the 4 million current users of cocaine, those who are using heavier doses of the drug and/or more potent versions of the drug, using it in a more dangerous way, and using it to a greater extent—all of those subsets apparently are increasing, so the total national picture gives cause for pessimism The actual severity of the problem among the using subgroup continues to worsen. As a result, the treatment demand often continues to worsen.

The trends in California are of particular interest to us because for the past decades California has been in many respects the bellwether State. And we are encouraged to find that among California adults, as well as young people and high school students nationally, we see the same trend with regard to the substantial reduction since the late seventies in the numbers of people who are using marijuana.

Now, how do we explain the fact that though supply remains high, the numbers of individuals using drugs are beginning to decline?

Senator HAWKINS. Go back to your other chart for a moment. How do you justify those figures showing cocaine going down when the number of emergency mentions for cocaine and heroin is way up?

Dr. POLLIN. Yet, those emergency room mentions and the overdose deaths, also, are continuing to increase. Our understanding is as follows: that the total number of people who are using these drugs, after climbing so steadily for 20 years, has begun to come down.

But the high numbers who are left are using in more dangerous ways.

What we have found has been a dramatic change in national attitudes with regard to the use of drugs. Again, in California you

will see that from the late sixties until 1979, as shown by the yellow line, the percentage of California adults who were in favor of legalization increased. The percentage of Californians in favor of stricter laws and stricter enforcement against the use of drugs decreased.

And then in the late 1970's that changed, and now we see a very encouraging increase in the percentage of Californians—and this is true nationally as well—who favor stricter laws and stricter enforcement of the laws against the use of drugs. We see the same trends in our surveys of young people.

The other thing that has changed has been the perception of the dangers and the health consequences by our population, and particularly by our young people, of the regular use of drugs.

This particular chart shows specifically—on that orange line—the percentage of high school seniors who believe that regular use of marijuana is a source of danger and harm. And again we see that during the early part of the 1970's there was a decreasing percentage of students who were concerned about the health effects of marijuana. But, beginning in the same year when use began to come down, students began to realize that this was a dangerous drug and that regular use would have serious health consequences.

Despite these encouraging trends, I cannot emphasize too strongly how serious the problem remains both in our view and in the view of our young people. I would like to introduce for the record a survey just recently released by the National Association of Secondary School Principals.

They surveyed 1,500 young people in grades 7 through 12 about many of their attitudes, perceptions, and beliefs about our current society. One of the questions that these young people were asked was to identify the single worst influence on the lives of young people today. Almost half of the students cited drugs as the single worst current influence. No other issue even came close to eliciting this level of response from the students.

The fact that despite the recent improvement, the young people themselves—to a four times greater extent than is true of their concern about peer pressure, alcohol, violence, the threat of war and the like—identified drugs as the single worst influence, the most dangerous influence, on themselves and their peers is just one among many measures of how serious this problem remains in our society today.

The encouraging change in attitudes and increase in the perception of health consequences which are several of the factors which have helped to reverse what had previously been an unending increase in the use of drugs in our society, are based in part, we think, on changes in demographics.

In addition, these changes are based on the fact that there has been a very healthy, sudden increase in the number of active community and parent groups around the country addressing themselves to this problem.

This shift is also, though, we think, due to the fact that research in the area, beginning in the late 1970's, has provided a lot more evidence and more convincing evidence of what the dangers of the use of these drugs actually consisted of.

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Some of our research has been directed at studying which ways of communicating these dangers work best with young people, and we feel that our prevention efforts have benefited from these research studies.

I would like to mention just very briefly some of our other research activities which we think are potentially most important and most exciting. Example: We have learned just in the past 10 years that our brains are not just remarkable switchboards and computers, but mini pharmaceutical factories.

Our brains manufacture their own narcotics, their own stimulants. As a result of learning about these chemicals produced in the brain, for the first time we are now able to begin to raise testable and answerable questions on the biological differences that contribute to the fact that some people experiment with drugs and get hooked and other pecple experiment with drugs and walk away from them.

We have begun to learn what the biology of the addictive process is different kinds of drugs, such as cocaine and heroin and different processes such as the reinforcement and pleasure derived from food and water, all go through the same very small biological pathway in the brain.

We have begun to apply this new knowledge in developing new and much more effective treatment techniques. And shortly, as an example, we hope that there will be approval for a totally new category of substances called narcotic antagonists which can completely block the effect of all narcotics on the brain. Treatment studies have shown that there are subgroups of narcotics users for whom this type of drug, treatment for addition, we think, will be very effective.

Finally, we are very concerned about and very interested in applying our research to special populations, including ethnic minorities whose demographics differ and who are thus at greater risk for increasing drug use in the future and to adolescents. We also wish to continue and expand the special focus with regard to women. We have had and continue to support programs along those lines. The special needs of women have been looked at in a fair number of studies in the past. We have uncovered some very important findings with regard, for example, to the special consequences of the use of drugs by pregnant women, the effects of marijuana on the size of the fetus, the effects of narcotics on women who are pregnant.

Over just the past few years, we have issued eight separate publications dealing with women's issues, including a two-volume set, recently produced, addressing treatment services to drug-dependent women. These works are highly regarded throughout the treatment field, but we certainly do agree that this is an area that can and should receive additional support and focal attention.

I would like to conclude my remarks now and would be glad to answer any questions that you might have.

[The prepared statement of Dr. Pollin follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C. 20201

FOR RELEASE ONLY UPON DELIVERY

STATEMENT OF

WILLIAM POLLIN, M.D.
DIRECTOR

NATIONAL INSTITUTE ON DRUG ABUSE
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON ALCOHOLISM AND DRUG ABUSE
OF THE
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

ON

REAUTHORIZATION OF EXPIRING RESEARCH AUTHORITIES
OF THE
NATIONAL INSTITUTE ON DRUG ABUSE

MAY 1, 1984

MADAME CHAIRMAN, AND MEMBERS OF THE SUBCOMMITTEE: I APPRECIATE YOUR INVITATION TO APPEAR BEFORE THE COMMITTEE TODAY TO DISCUSS REAUTHORIZATION OF THE RESEARCH PROGRAM OF THE NATIONAL INSTITUTE ON DRUG ABUSE (NIDA). THE PRESIDENT'S FY 1985 BUDGET FUNDS NIDA'S RESEARCH ACTIVITIES AT $63.5 MILLION, AN INCREASE OF $9 MILLION, OR 16 PERCENT, ABOVE FY 1984. THE ADMINISTRATION'S BILL TO REAUTHORIZE THIS RESEARCH PROGRAM WILL BE SUBMITTED SHORTLY. I CAN BEST DESCRIBE NIDA'S PROGRAMS BY DISCUSSING THE EXTENT OF THE DRUG ABUSE PROBLEM AND OUR ROLE AS THE LEADING FEDERAL AGENCY IN DEMAND REDUCTION EFFORTS. FIRST, LET ME SUMMARIZE THE DIMENSIONS OF THE DRUG ABUSE PROBLEM IN AMERICA.

DEMOGRAPHICS OF THE PROBLEM

DRUG ABUSE IS CLEARLY A MAJOR PUBLIC HEALTH PROBLEM WITH UNIQUE CHARACTERISTICS. DRUG ABUSE PATTERNS CHANGE VERY RAPIDLY, AS DEMONSTRATED BY THE NEARLY 30-FOLD INCREASE IN MARIJUANA USE BY YOUNG PEOPLE BETWEEN THE LATE 1950S AND THE LATE 1970S. ADDITIONALLY, THERE ARE ILLEGAL AND HIGHLY PROFITABLE ACTIVITIES UNDERTAKEN WORLDWIDE TO ACTIVELY PROMOTE DRUG ABUSE. THE STEADY INCREASE IN DRUG ABUSE HAS NOT BEEN LIMITED TO MARIJUANA; THERE HAS BEEN A VERY SUBSTANTIAL INCREASE IN USE OF MOST OTHER DRUGS DURING THE SAME APPROXIMATE TIME PERIOD.

A LEVELING OFF OR BEGINNING DECLINE IN THE USE OF MANY DRUGS HAS OCCURRED SINCE PEAK LEVELS WERE OBSERVED IN THE LATE 1970S. NONETHELESS, DRUG USE LEVELS IN THE UNITED STATES REMAIN UNACCEPTABLY AND DANGEROUSLY HIGH. FOR INSTANCE, IN 1983, MORE HIGH SCHOOL SENIORS REPORTED THAT MOST OR ALL OF THEIR FRIENDS USED MARIJUANA THAN THAT NONE OF THEIR FRIENDS USED THE DRUG. NEARLY AS MANY HIGH SCHOOL SENIORS ARE CURRENT USERS OF MARIJUANA AS ARE CURRENT CIGARETTE SMOKERS. DRUG USE IN THE WORKPLACE IS ALARMINGLY HIGH, AND RECENT STUDIES IN SEVERAL MAJOR INDUSTRIES HAVE FOUND THAT BETWEEN 30 PERCENT AND 70 PERCENT OF EMPLOYEES AND/OR JOB APPLICANTS HAD ILLEGAL DRUGS IN THEIR SYSTEMS WHEN TESTED AT THE WORKSITE. THESE LEVELS OF DRUG ABUSE BY YOUNGSTERS AND YOUNG ADULTS REPRESENT A TOTALLY NEW PHENOMENON AS FAR AS HEALTH EPIDEMICS ARE CONCERNED. TO UNDERSCORE THE CURRENT SERIOUSNESS OF THE PROBLEM, PARTICULARLY AMONG YOUTH, WE MUST CONSIDER THAT DESPITE OUR EFFORTS:

- NEARLY TWO OUT OF THREE YOUNG PEOPLE TRY AN ILLICIT DRUG BEFORE THEY FINISH HIGH SCHOOL. (64 PERCENT)
- ALMOST ONE IN EVERY 18 HIGH SCHOOL SENIORS IS ACTIVELY USING MARIJUANA ON A DAILY OR NEAR DAILY BASIS, AND APPROXIMATELY 20 PERCENT HAVE DONE SO FOR AT LEAST A MONTH AT SOME TIME IN THEIR LIVES.
- ABOUT ONE IN EVERY 16 SENIORS IS DRINKING ALCOHOL DAILY, AND OVER 40 PERCENT HAVE HAD FIVE OR MORE DRINKS, AND/OR BEEN DRUNK, AT LEAST ONCE DURING THE PAST TWO WEEKS.
- ONE-THIRD OF THE AMERICAN HOUSEHOLD POPULATION OVER AGE 12 HAVE USED MARIJUANA, COCAINE, HEROIN, OR ANOTHER PSYCHOACTIVE DRUG FOR NONMEDICAL PURPOSES AT SOME TIME DURING THEIR LIVES. IN ADDITION, ABOUT ONE IN EVERY FIVE AMERICANS IN HOUSEHOLDS SURVEYED HAS USED ONE OF THESE DRUGS DURING THE PAST YEAR.

HOWEVER, AS I NOTED EARLIER, THE USE OF MANY DRUGS HAS BEGUN TO DECLINE. THESE DECLINES ARE DOCUMENTED BY A VARIETY OF SOURCES, INCLUDING OUR HIGH SCHOOL SENIOR SURVEY AND NATIONAL HOUSEHOLD SURVEY, A VARIETY OF STATE SURVEYS, AND MULTIPLE PUBLIC OPINION POLLS.

ALTHOUGH THE OVERALL PERCENTAGES OF NEW AND CURRENT DRUG USERS IN THIS COUNTRY'S POPULATION ARE DECREASING OR LEVELING-OFF, DRUG USE BY OUR YOUNG PEOPLE CONTINUES TO BE VIEWED BY OUR LEADING EXPERTS AS PROBABLY THE HIGHEST IN THE WESTERN INDUSTRIALIZED WORLD. THESE GRIM FACTS REQUIRE OUR CONTINUED PRIORITY ATTENTION AND CONCERN TO THE DRUG PROBLEM IN AMERICA.

THE DESTRUCTIVE EFFECTS OF DRUGS ON THE HEALTH OF THOSE WHO ABUSE THEM ARE A MAJOR CONCERN OF OURS. WE GATHER INFORMATION ON THE CURRENT, ACUTE NEGATIVE HEALTH CONSEQUENCES OF DRUG USE, SUCH AS DRUG OVERDOSES, THROUGH THE DRUG ABUSE WARNING NETWORK (DAWN). THROUGH THE DAWN SYSTEM, WHICH IS COMPRISED OF 758 EMERGENCY ROOM AND MEDICAL EXAMINER FACILITIES LOCATED PRIMARILY IN 26 METROPOLITAN AREAS THROUGHOUT THE UNITED STATES, NIDA RECEIVES REPORTS ON DRUG-RELATED CASES ON AN ONGOING BASIS. AND, ALTHOUGH LEVELS OF USE HAVE PEAKED OR ARE BEGINNING TO DECLINE, PARTICULARLY AMONG YOUTH, PATTERNS OF HEAVIER AND MORE DANGEROUS USE, OR USE OF MORE POTENT MATERIALS, ARE PRESENT AMONG LARGE SUBGROUPS OF USERS. THIS SOMETIMES RESULTS IN THE APPEARANCE OF SEEMINGLY CONTRADICTORY

TRENDS; THAT IS, A DECREASE IN THE OVERALL NUMBER OF USERS NATIONWIDE, BUT AN INCREASE IN THE NUMBER WHO ARE ADDICTED AND NEED TREATMENT, OR IN THE NUMBER OF DRUG RELATED DEATHS AND MEDICAL COMPLICATIONS AS REPORTED BY HOSPITAL EMERGENCY ROOMS AND MEDICAL EXAMINERS.

INSTANCES OF THESE APPARENTLY CONTRADICTORY TRENDS ARE EVIDENT WHEN CONSIDERING BOTH HEROIN AND COCAINE. WHILE USE OF HEROIN AND OTHER OPIATE DRUGS HAS NOT INCREASED APPRECIABLY SINCE 1981, SUBGROUPS OF HEAVY USERS, BY INCREASING THEIR CONSUMPTION, HAVE CAUSED AN INEVITABLE INCREASE IN MEASURES OF THE MEDICAL AND SOCIAL CONSEQUENCES ASSOCIATED WITH THESE DRUGS. USE OF COCAINE ALSO HAS SHOWN SIGNS OF LEVELING OFF AMONG HIGH SCHOOL SENIORS, BUT THE MEDICAL EMERGENCIES ASSOCIATED WITH MORE INTENSE USE OF THIS DRUG ARE INCREASING AT AN ALARMING RATE.

WE COLLECT DATA NOT ONLY ON THE INCIDENCE AND PREVALENCE OF DRUG ABUSE AND ITS ACUTE HEALTH CONSEQUENCES, BUT ALSO ON DRUG ABUSE TREATMENT ACTIVITIES. THE NATIONAL DRUG AND ALCOHOLISM TREATMENT UTILIZATION SURVEY (NDATUS) LOOKS AT THE SCOPE AND USE OF DRUG ABUSE AND ALCOHOLISM TREATMENT AND PREVENTION RESOURCES THROUGHOUT THE UNITED STATES AND ITS TERRITORIES. THIS NDATUS INFORMATION, ON A SUBSTANTIAL PORTION OF THE TREATMENT RESOURCES, PROVIDES A CONSISTENT SUMMARY FROM YEAR-TO-YEAR.

IN 1984, NDATUS IS PROPOSED AS A JOINT EFFORT WITH THE NATIONAL

INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM (NIAAA) AND THE STATES. THIS BIENNIAL VOLUNTARY EFFORT WILL BE MODIFIED TO MORE CLOSELY REFLECT THE CAPABILITIES AND NEEDS OF THE STATES. IT WILL BE USED BY FEDERAL AND STATE AGENCIES TO ASCERTAIN THE KINDS OF TREATMENT AVAILABLE, THE NUMBERS OF CLIENTS BEING TREATED, AND FLUCTUATIONS IN FUNDING ALLOCATIONS FOR THOSE SERVICES.

RESEARCH

NIDA HAS THE PRIMARY FEDERAL RESPONSIBILITY FOR RESEARCH INTO THE USE AND ABUSE OF DRUGS. PRIOR TO PASSAGE OF THE OMNIBUS BUDGET RECONCILIATION ACT IN 1981, NIDA'S MAJOR BUDGET COMMITMENTS WERE DIRECTED TOWARD PREVENTION AND TREATMENT SERVICE PROGRAMS (66 PERCENT), WITH A SMALLER AMOUNT (18 PERCENT) ALLOCATED TO EFFORTS IN BASIC BIOMEDICAL, BEHAVIORAL, TREATMENT, ABUSE-LIABILITY AND DRUG HAZARD RESEARCH, AND TO EPIDEMIOLOGIC ACTIVITIES. WITH THE TRANSFER OF DRUG ABUSE TREATMENT AND PREVENTION SERVICES TO THE STATES UNDER THE ADMS BLOCK GRANT PROGRAM, NIDA HAS REORGANIZED IN ORDER TO FULFILL THE INSTITUTE'S SUBSTANTIALLY MODIFIED ROLE, IN WHICH RESEARCH CONSTITUTES 80 PERCENT OF OUR TOTAL BUDGET.

THE CHANGE IN OUR PRIMARY MISSION TO ONE OF RESEARCH COMES AT A PARTICULARLY OPPORTUNE TIME. BUILDING ON RESEARCH ACCOMPLISHMENTS OF THE PAST SEVERAL YEARS, NIDA SUPPORTED RESEARCH HAS DEVELOPED INFORMATION SO BASIC TO THE FUNDAMENTAL ACTION OF THE BRAIN THAT A

WHOLE NEW AREA OF SCIENTIFIC INQUIRY HAS DEVELOPED. FROM OUR STUDIES OF THE BASIC MECHANISMS UNDERLYING SUBSTANCE ABUSE, IT IS BECOMING INCREASINGLY CLEAR THAT DRUG ABUSE IS A PROBLEM WHICH IS NOT JUST SOCIAL IN NATURE, BUT ONE WITH AN IMPORTANT BIOLOGICAL COMPONENT AS WELL. EXPLORATION OF THE PHYSICAL ASPECT OF SUBSTANCE ABUSE IS NOW THE MAJOR FOCUS OF OUR RESEARCH PROGRAM. INCLUDED IN OUR INVESTIGATIONS HAVE BEEN STUDIES TO DETERMINE WHY SOME DRUGS ARE ABUSED WHILE OTHERS ARE NOT. RESULTS FROM THESE STUDIES HAVE DEMONSTRATED THAT THE BRAIN ACTS AS A PHARMACOLOGIC FACTORY, AS WELL AS A CENTRAL COMPUTER DIRECTING MESSAGES THROUGHOUT THE BODY. IT MANUFACTURES, FOR INSTANCE, ITS OWN SUBSTANCES WHICH ARE CHEMICALLY SIMILAR TO ABUSED DRUGS SUCH AS HEROIN AND MORPHINE. NOW THAT THESE NATURALLY OCCURRING DRUGS, CALLED ENDORPHINS, HAVE BEEN DISCOVERED AND THEIR LOCATION IN THE BRAIN IDENTIFIED, OUR RESEARCH CAN BEGIN TO STUDY THE FUNCTION THEY PLAY IN MODULATING PAIN, AS WELL THEIR POSSIBLE ROLE IN HUNGER AND OTHER BASIC PROCESSES. MOST RELEVANT, WE CAN EXPLORE THE POSSIBILITY THAT THE REASON SOME PEOPLE BECOME ADDICTS, AND OTHERS DO NOT, RESULTS FROM BIOLOGICAL DIFFERENCES IN THESE SYSTEMS. OUR STUDIES OF THE ENDORPHINS HAVE BOTH PROMPTED AND CAPITALIZED ON ADVANCES IN RESEARCH TECHNOLOGY. SOPHISTICATED NEW EQUIPMENT AND METHODS, SUCH AS BRAIN IMAGING AND SYNTHETIC DRUG DEVELOPMENT, ENABLE US TO IDENTIFY THE "REWARD" MECHANISMS OF DRUG ABUSE BEHAVIOR AND FOCUS OUR STUDIES ON THE COMMON NEURAL MECHANISMS OF MANY COMPULSIVE DISORDERS, INCLUDING OVEREATING AND CIGARETTE SMOKING, AS WELL AS ON ABUSE OF DRUGS OTHER THAN THE OPIATES.

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OUR FINDINGS HAVE BEEN SO BASIC TO UNDERSTANDING THE FUNDAMENTAL ACTION OF THE BRAIN THAT THEY HAVE ALLOWED US TO SEARCH FOR OTHER NATURAL SUBSTANCES AND THEIR "RECEPTORS". FOR INSTANCE, STUDIES HAVE BEEN INITIATED WHICH SEEK TO IDENTIFY AND DESCRIBE THE ACTION OF RECEPTORS FOR SUCH DRUGS AS NICOTINE, CANNABIS, AND THE BENZODIAZEPINES. OUR NEUROSCIENCE RESEARCH PROGRAM CAN ALSO NOW FOCUS ON SPECIFIC QUESTIONS SUCH AS THE HERITABILITY OF ADDICTIVE DISORDERS AND THE BIOCHEMICAL GENETICS OF DIFFERENT NATURALLY OCCURRING OPIATE-LIKE SUBSTANCES.

IN THE LAST FEW YEARS WE HAVE GREATLY EXPANDED OUR RESEARCH INTO BOTH MARIJUANA AND COCAINE. RECENT STUDIES OF THESE SUBSTANCES HAVE BEEN DIRECTED AT TWO MAJOR ISSUES: (1) THE HEALTH EFFECTS OF CHRONIC USE AND (2) THE HEALTH AND BEHAVIORAL EFFECTS OF SHORT-TERM USE. INITIAL RESULTS SHOW EVIDENCE OF THE ADVERSE EFFECTS OF CHRONIC USE OF MARIJUANA ON REPRODUCTIVE FUNCTION, THE IMMUNE SYSTEM, SOCIAL AND PSYCHOLOGICAL DEVELOPMENT, AND POSSIBLY ON PULMONARY AND RESPIRATORY FUNCTION. STUDIES INTO COCAINE, THE MOST POTENT REINFORCING DRUG CURRENTLY KNOWN, SHOW THAT IT CAN EITHER LOWER OR RAISE THE BRAIN'S THRESHOLD FOR EXPERIENCING PLEASURE, DEPENDING ON DIFFERING ENVIRONMENTAL CONDITIONS. THIS FINDING, COUPLED WITH WELL DOCUMENTED EXAMPLES OF THE DRAMATIC ADVERSE HEALTH AND SOCIAL CONSEQUENCES ASSOCIATED WITH COCAINE USE, MAKES ACCELERATED RESEARCH INTO THIS DRUG A HIGH PRIORITY.

THE IMPACT OF DRUG ABUSE ON WOMEN IS ANOTHER OF OUR RESEARCH PRIORITIES. THE INSTITUTE'S 1982 SURVEY DATA INDICATE THAT APPROXIMATELY 30 PERCENT OF ALCOHOL AND DRUG ABUSE CLIENTS ARE WOMEN. TO ADDRESS THE SPECIAL NEEDS OF THIS GROUP, NIDA IS CURRENTLY SUPPORTING RESEARCH STUDIES ON THE PROVISION OF TREATMENT SERVICES TO WOMEN. FOR EXAMPLE, WE ARE LOOKING AT THE SPECIFIC NEEDS AND CONCERNS OF THE FEMALE CLIENTS AS COMPARED TO THE MALE CLIENTS, IN STATE AND LOCAL SERVICE PROGRAMS. WE ARE ALSO INVESTIGATING THE EFFICACY OF SPECIAL OUTREACH PROGRAMS DESIGNED FOR FEMALE CLIENTS.

SEVERAL INVESTIGATORS CONTINUE LONG-TERM STUDIES OF THE EFFECTS OF DRUGS ON PREGNANCY, DEVELOPMENT OF THE FETUS, AND OFFSPRING. OVER THE PAST FEW YEARS, NIDA HAS ISSUED EIGHT PUBLICATIONS DEALING WITH WOMEN'S ISSUES, INCLUDING A TWO-VOLUME SET ADDRESSING TREATMENT SERVICES TO DRUG-DEPENDENT WOMEN. THESE WORKS ARE HIGHLY REGARDED THROUGHOUT THE TREATMENT FIELD.

OUR LEADERSHIP HAS ALSO BEEN EVIDENT IN THE AREAS OF TREATMENT EFFECTIVENESS AND PREVENTION RESEARCH. NIDA'S INTRAMURAL RESEARCH PROGRAM, AT THE ADDICTION RESEARCH CENTER IN BALTIMORE, PROVIDES THE CONTINUITY NECESSARY FOR MANY LONG-TERM PROJECTS, SUCH AS STUDIES OF THE EFFECTIVENESS AND SAFETY OF NEW TREATMENT AGENTS AND THE DEVELOPMENT OF ORPHAN DRUGS. THROUGH LARGE-SCALE STUDIES CONDUCTED OVER THE PAST SEVERAL YEARS, NIDA HAS EVALUATED THE EFFECTIVENESS OF

DRUG ABUSE TREATMENT MODALITIES. FINDINGS FROM THESE STUDIES SHOW THAT APPROPRIATE TREATMENT IS EFFECTIVE IN REDUCING DRUG USE AND CRIMINAL ACTIVITY WHILE IMPROVING PATIENTS PRODUCTIVITY.

RESEARCH STUDIES HAVE ALSO SHOWN THAT DRUG ABUSE PREVENTION EFFORTS CAN BE EFFECTIVE. FUNDAMENTAL TO DESIGNING EFFECTIVE PROGRAMS, HOWEVER, IS THE REALIZATION THAT DRUG ABUSE IN ADOLESCENTS RESULTS NOT PRIMARILY FROM THEIR LACK OF KNOWLEDGE ABOUT DRUG EFFECTS, BUT FROM A COMPLEX INTERACTION OF COGNITIVE, PSYCHOLOGICAL, SOCIAL AND ENVIRONMENTAL FACTORS. ACCORDINGLY, NIDA'S PREVENTION RESEARCH IS DESIGNED TO ENCOURAGE THE DEVELOPMENT OF PREVENTION STRATEGIES BASED ON A SOUND FOUNDATION IN THE BEHAVIORAL SCIENCES.

IN FACT, EARLY RESULTS FROM PREVENTION RESEARCH STUDIES ARE ENCOURAGING AND SUGGEST THAT INTERVENTION EFFORTS, INCLUDING THOSE OF PARENTS HAVE ALREADY PLAYED A ROLE IN REDUCING BY MORE THAN ONE-HALF THE LEVEL OF DAILY MARIJUANA USE BY HIGH SCHOOL SENIORS AND OTHER TEENAGERS. FUTURE PRIORITIES INCLUDE FURTHER EXPLORATION OF WAYS TO REDUCE SOCIAL PRESSURES TO USE DRUGS IN DIFFERENT CULTURAL AND ETHNIC GROUPS. FAMILY ORIENTED PREVENTION STRATEGIES WILL ALSO BE EXPLORED, CONCENTRATING ON THE FAMILY'S ABILITY TO PROMOTE HEALTHY MATURATION AND PREVENT DRUG ABUSE.

APPLICATION OF STRATEGIES WE ALREADY KNOW TO BE EFFECTIVE WILL CONTINUE TO RECEIVE HIGH PRIORITY. BY LENDING TECHNICAL ASSISTANCE,

CONVENING WORKSHOPS AND CONFERENCES, AND PUBLISHING A VARIETY OF MATERIALS, NIDA CONTINUES TO SEEK WAYS TO SUPPORT PARENTS GROUPS. OUR BOOKLET, PARENTS, PEERS AND POT WAS DEVELOPED FOR PARENTS GROUPS AND HAS BEEN THE MOST WIDELY REQUESTED NIDA PUBLICATION. RECENTLY WE DEVELOPED PARENTS, PEERS AND POT II: PARENTS IN ACTION, A BOOK DESCRIBING THE FORMATION AND EXPERIENCES OF SELECTED PARENT GROUPS IN URBAN, SUBURBAN, AND RURAL COMMUNITIES. CURRENTLY, NIDA IS COLLABORATING WITH ACTION AND THE NATIONAL FEDERATION OF PARENTS TO EXPAND AND ENHANCE INVOLVEMENT OF ETHNIC MINORITY FAMILIES IN THE PARENT MOVEMENT FOR DRUG FREE YOUTH.

THESE ARE JUST SOME EXAMPLES OF HOW NIDA CONTINUES TO DISSEMINATE RESEARCH FINDINGS AND TECHNICAL INFORMATION ON DRUG ABUSE TO STATE AND LOCAL GOVERNMENTS AND SERVICE PROVIDERS. IN ADDITION, NIDA LENDS ASSISTANCE AND PROVIDES INFORMATION TO A VARIETY OF PUBLIC AND PRIVATE SECTOR GROUPS ACTIVELY CONCERNED WITH DISCOURAGING DRUG ABUSE. IN THE PAST FEW YEARS WE HAVE REACHED MANY PEOPLE THROUGH NATIONAL MEDIA CAMPAIGNS AND COLLABORATION WITH NATIONAL ORGANIZATIONS, AS WELL AS BY CONTINUING TO DEVELOP AND PRINT NUMEROUS PUBLICATIONS. THROUGH THESE ACTIVITIES, AND OUR PREVENTION RESEARCH PROGRAM, NIDA CONTINUES TO PROVIDE EFFECTIVE NATIONAL LEADERSHIP IN THE DRUG ABUSE PREVENTION AREA.

MADAME CHAIRMAN, THIS CONCLUDES MY FORMAL STATEMENT, BUT I NOW WILL BE HAPPY TO ANSWER ANY QUESTION YOU MAY HAVE ABOUT OUR PROGRAMS.

Senator HAWKINS. Dr. Pollin, the California survey revealed that marijuana use is down. What did it reveal about cocaine?

Dr. POLLIN. The particular survey that I referred to here focused exclusively on marijuana; it did not look at cocaine. But our nationwide statistics about cocaine do indicate that the use of cocaine nationally has peaked, but subgroups are continuing to increase their usage.

Senator HAWKINS. That is the 5-minute bell. I will have to go vote, and I will be right back. We will adjourn at the moment.

[A brief recess was taken.]

Senator HAWKINS. Back on the record, please.

Dr. Niven, I apologize for the interruption.

Dr. NIVEN. That is fine. It is also a privilege, Madam Chairman, for me to appear for the first time, and I hope not for the last time, before the committee to comment and discuss the issues related to the reauthorization of NIAAA's research activities.

The President's fiscal year 1985 budget requests funds for NIAAA research at a level of $47.8 million. We believe this level is necessary to carry out the research which is related to the adverse effects of alcohol consumption in our society, which were described at a recent conference as the major preventable public health problem in our society today.

Some may think this is somewhat debatable, but I believe if you add up the public health problems related to alcohol consumption and combine that with the problems related to the use of other psychoactive drugs that fall under the purview of NIDA, I think we clearly have this Nation's No. 1 public health problem.

We appreciate the support that this committee has shown for NIAAA in previous years and for its research activities, and would like to certainly invite your, other subcommittee members, and staff to visit any of the clinical or basic research programs at the NIH in our clinical research facility, or in any of the national alcoholism research centers that are in various parts of the country.

I would like to simply limit my comments to a couple of general comments about our research and then, with your permission, submit for the record testimony which outlines our research activities in some greater detail.

The comments that Dr. Pollin made relevant to some long-term trends with other psychoactive drugs are in many ways also applicable to alcohol. Despite the fact that there seems to be a plateauing or, with some specific populations, the beginnings of a very slight decline in overall levels of alcohol consumptions, the problems associated with that consumption remain major and in many instances not fully understood.

There is, however, in the last few years a very gratifying heightened awareness and I think a sensitivity and a determination on the part of the public to do something about the major toll that alcohol-related problems cause in our society.

As I know you are aware, alcohol abuse and dependence are a major cause of accidental deaths in this country. Of the approximately 100,000 traumatic deaths per year, alcohol consumption is related, I think quite conservatively, to at least 40,000, or 40 percent of them.

With certain kinds of accidents, it is much higher; with some it is a little bit lower, but it is a major contributor to mortality and morbidity in this country.

The other gratifying trend, combined with the first one, that gives us a tremendous opportunity to make a positive impact on alcohol problems is the increasing attraction to alcohol research of very highly qualified researchers from a variety of disciplines.

There has always been a small number of very good researchers in this field, but as our knowledge advances and as some of the stigma associated with alcohol and drug abuse research—and there is a stigma associated with research, not just with having the problem or being in treatment for it—as that disappears, we are attracting more researchers.

I would stop my comments there. With your permission, we will simply submit for the record a more detailed description of our research activities.

[The prepared statement of Dr. Niven follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Alcohol, Drug Abuse, and
Mental Health Administration
Rockville MD 20857

For Release Only Upon Delivery

STATEMENT

BY

DR. ROBERT G. NIVEN, DIRECTOR

NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

ON

REAUTHORIZATION OF NIAAA PROGRAMS

BEFORE THE

SUBCOMMITTEE ON ALCOHOLISM AND DRUG ABUSE

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

TUESDAY, MAY 1, 1984

Madame Chairman and Members of the Subcommittee:

It is a pleasure for me to appear here today to discuss reauthorization of the research activities of the National Institute on Alcohol Abuse and Alcoholism (NIAAA). I am particularly pleased to make my first appearance before you with Dr. William Pollin, with whom I frequently collaborate on the preventable and pressing problems of alcohol and drug abuse in our society. I believe that timely reauthorization of these research authorities is of critical importance in allowing us to capitalize on many new and promising avenues of research. The President's fiscal year 1985 budget funds NIAAA's research activities at $47.8 million, an increase of $5 million or 11% above fiscal year 1984. The Administration's bill to reauthorize this research program will be submitted shortly.

Though relatively new to my position, I have already learned of the dedication and support this Subcommittee has shown over the years to the problems of alcohol abuse and alcoholism. We look forward to your leadership, Madame Chairman, as together we continue to strive for a better understanding of alcohol abuse and of alcoholism, a disease which has taken and continues to take a devastating toll on this Nation.

Today, I would like to describe primarily NIAAA's scientific programs and some of the particularly promising areas of research.

NIAAA PROGRAMS

We are proud of the quality of and support for our research in alcoholism and alcohol-related problems.

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Let me take a moment to describe some of the activities we have undertaken to assist in establishing our research priorities and setting directions. Five years ago the Institute commissioned a landmark report by the Institute of Medicine of the National Academy of Science which reviewed the state-of-the-art of research on alcohol abuse and alcoholism and made recommendations for the direction of future research. More recently we convened and received recommendations from a Research Planning Panel comprised of some of the most distinguished scientists in the Nation. We have also established a Board of Scientific Counselors to periodically review our intramural program. The converging opinion of these expert bodies indicates we are making remarkable gains in our knowledge about alcohol abuse and alcoholism. I would like now to comment briefly on some of our research activities.

NIAAA currently administers a multi-component research program including intramural and extramural research programs, a research training program, and activities relating to the dissemination of our research findings.

Intramural

The intramural program conducts basic and applied research into the causes and processes of alcoholism and other alcohol-derived health problems. The new alcohol research ward located in the Clinical Center at the NIH campus provides both an inpatient and outpatient program of clinical research. One very important aspect of this program is to conduct studies on familial transmission of alcoholism. In support of

these studies the program is recruiting relatives of alcoholic patients for detailed psychological, physiological and neurochemical studies and comparison with carefully matched controls who do not have a family history of alcoholism. Particular attention will be given to studying the children of alcoholics. The research of the nonclinical laboratories will continue to concentrate on expanding our understanding of the metabolism of alcohol, its effects on the cell and on the excitability and functioning of the nervous system, and the development and impact of tolerance, dependence, and withdrawal.

Extramural

Our extramural program is conducted through a variety of mechanisms, including not only traditional research grants and our national alcohol research centers but also new investigator research awards, research scientist development awards and research scientist awards.

The national centers carry out studies in many areas such as effects of alcohol on brain function, pathological consequences of alcohol, and on genetic factors. The one in your State, located in Gainesville, is studying the causes and consequences of alcoholism and alcohol abuse on a very vulnerable population, the elderly.

In FY 1984, we will be awarding 240 projects in our extramural program; in FY 1985, we expect to increase these

to 275 projects.

We believe the quality of these research proposals is outstanding as evidence by the priority scores received by these applications under the peer review system used by NIAAA, the same system used by the other Institutes of the Alcohol, Drug Abuse, and Mental Health Administration and the National Institutes of Health. Particularly in the past year, we have had notable success in attracting applications from prestigious researchers throughout the Nation.

Research Training

Our research training program deserves special mention. We need to continue building the necessary pool of highly qualified scientists to carry on the excellent science already begun. In FY 1985, we expect to support 56 trainees.

Dissemination of Research Findings

We view the timely dissemination of research findings--particularly those in the prevention and treatment areas--as a high priority. Our National Clearirghouse for Alcohol Information, located in Rockville, Maryland, assists in disseminating research findings and other techincal information to the research community, State

and local governments and private sector groups, including health care professionals. We are planning another public education campaign aimed at preventing alcohol abuse in an extremely vulnerable population--the young adolescent--as well as national conferences on specific topics and to targeted audiences.

I would now like to move to the research opportunities in alcohol abuse and alcoholism.

PROMISING AREAS OF RESEARCH

The alcohol research field is on the threshold of some exciting gains in knowledge and understanding about a disorder that has long plagued society.

There is convincing evidence, gathered over the past few years, that there is a genetic predisposition to alcoholism in perhaps 40 to 50 percent of the patients that we see. This knowledge now makes it possible to conceptualize alcoholism in terms of the interaction between biological predisposing factors and the psychological and environmental risk factors that promote drinking. One of the most exciting and challenging tasks facing the alcohol field now is the task of finding out what, precisely, is inherited and how these inherited biological factors interact with other facets of the individual's life to produce disease.

Recent gains in knowledge about the genetics of alcoholism, the impact of alcohol at the subcellular level, and the biochemistry of human alcohol

metabolism have opened up avenues of research that were nonexistent a few years ago and that promise to yield new knowledge that will have an important impact on prevention and treatment strategies of the future. Contributing to the wide range of opportunity for productive biomedical research are new technologies such as molecular biology, the new imaging techniques, and recombirant DNA.

The behavioral sciences also hold promise. We are in a position now to expand our understanding of the nature of psychological and environmental risk for alcohol problems. It is known that such factors have a role in problem development, even in most individuals who have a genetic predisposition, and probably have the ascendency in problems such as teenage drinking and drinking and driving. The identification of psychosocial risk factors can help us target prevention and intervention efforts.

Alcohol Genetics and Metabolism

Investigating the metabolism of alcohol is among the most promising opportunities for research into the biology of alcoholism. We know that there is genetic variability in alcohol metabolic capacity and rate. We need to continue our research to isolate and characterize the many isoenzymes of alcohol metabolism and to learn how differing isoenzyme patterns correlate with differing metabolic rates and with risk for abusive drinking.

As an example, through research, we recently discovered an apparent relationship between the alcohol-flush reaction seen in certain Asian populations and the genetic absence of a specific isoenzyme.

In individuals lacking this isoenzyme, even small amounts of alcohol can cause facial flushing, and rapid heart rate and, in severe cases, nausea, vomiting and low blood pressure. Further research may provide a better understanding of the genetic basis of alcoholism, and thus, may pave the way for the development of agents to block the intoxicating and addictive effects of alcohol.

Cell Membrane

Recently gained knowledge about the actions of alcohol on the cell also holds promise. Using the modern techniques of physical biochemistry, enzymology, electrophysiology and neurochemistry, we have learned that alcohol alters the physical properties of cell membranes. When alcohol is present, membranes become more fluid. With chronic use the membrane composition changes to render it more rigid. The latter may constitute a biochemical basis for the development of tolerance to alcohol. We know that there is genetic variability in sensitivity to these effects. We obviously have a very basic finding here--a scientific lead which, if followed, should clarify the processes of intoxication and tolerance development.

Toxic Effects of Alcohol on the Fetus

One of the most noteworthy advances in alcohol research is the knowledge gained about the effects of alcohol consumption during pregnancy and its toxic effects on the fetus. Incidence of the Fetal Alcohol Syndrome (FAS) is in the range of one to three per

1000 births. The incidence of FAS among offspring of women identified as problem drinkers is estimated at 25 per 1000. It has been estimated that about 5 percent of all congenital defects may result from exposure of the fetus to alcohol. Children with FAS may exhibit mental retardation, growth deficits and a range of other abnormalities. Of particular importance for continued research are questions concerning the levels of maternal drinking at which damage occurs and the periods during pregnancy when there is greatest risk.

The Surgeon General, in 1981, issued an advisory on Alcohol and Pregnancy. It advises women who are pregnant not to drink beverage alcohol and to be aware of the alcohol content of food and drugs.

Alcohol-Related Trauma

Madame Chairman and Members of the Subcommittee, nothing can be more alarming, wasteful, and devastating than the carnage this Nation experiences daily through alcohol-involved accidents. We hear about some on the news and read about others in our newspapers. Still others go undetected. The list is lengthy--falls, burns, poisonings, other recreational, home, and occupational accidents as well as the myriad of vehicular accidents (train, auto, airplane, boat, snow mobile) to mention only some.

Probably the most recognized alcohol safety-related effort has been focused on the drinking driver. This effort is to be commended. But it is only a beginning. Home accidents, including fires and falls,

disproportionatly affect the elderly, an already vulnerable group, particularly when alcohol is involved. Worksite "performance impairment" because of alcohol is an important issue to many of our businesses and others who are interested in morbidity, mortality, and productivity. As a physician, I have become aware of the need for sustained and enhanced education of physicians and other health care professionals to the problems of alcohol and drug abuse.

Preliminary studies show alcohol also has played a significant role for both the perpetrators and the victims of numerous interpersonal traumas, including homicide, suicide, child abuse, and rape. Continued research is needed to better understand alcohol's role in these traumas.

Madame Chairman, accidents are a leading cause of death (number one for those under 44 years of age), mortality, and years of lost life. We need to try to reduce these levels. Trauma medicine is emerging as a new, important specialty. Yet there is practically no research in this area. We are in the process of mounting a several year, fulti-faceted effort to further understand the exact role of how alcohol interacts with other factors in accidents. Through such understanding, we will be in a better position to facilitate intervention and prevention efforts.

Madame Chairman, this concludes my formal remarks. I will be happy to answer any questions you may have. And I would invite you and the other distinguished members of this Subcommittee to visit our new intramural clinical research ward located at the Clinical Center on the NIH campus.

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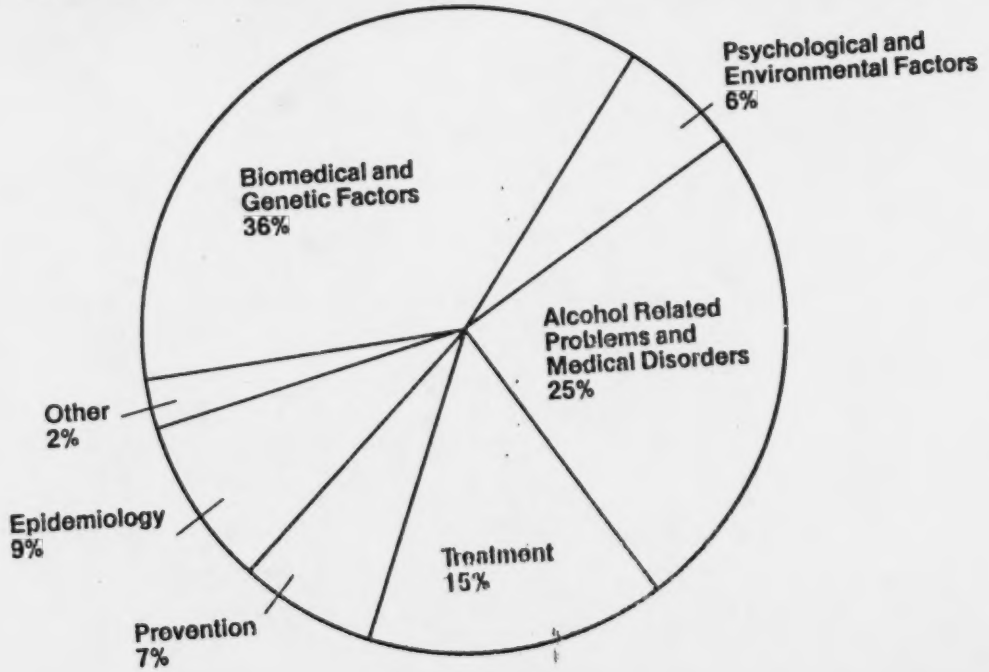
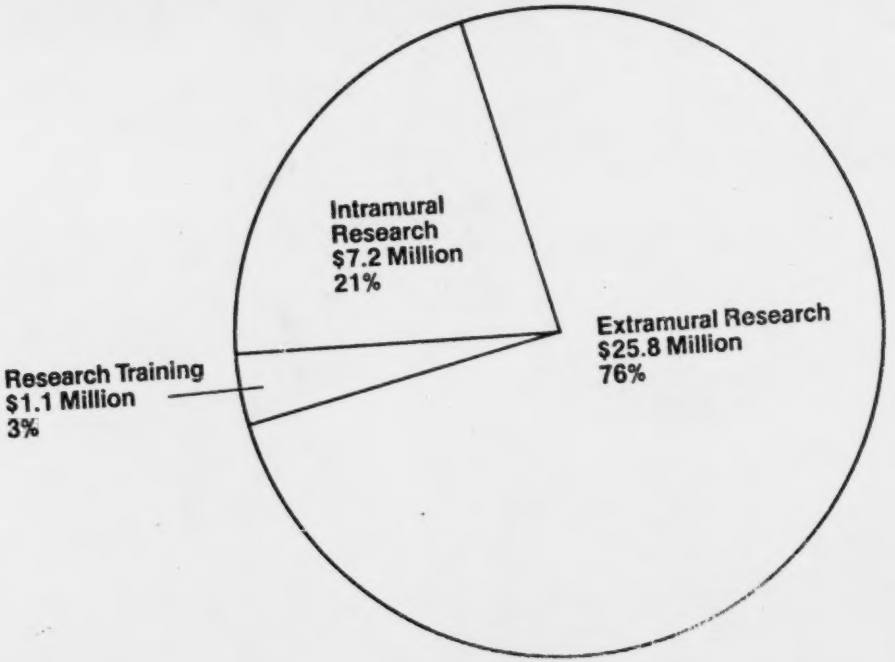
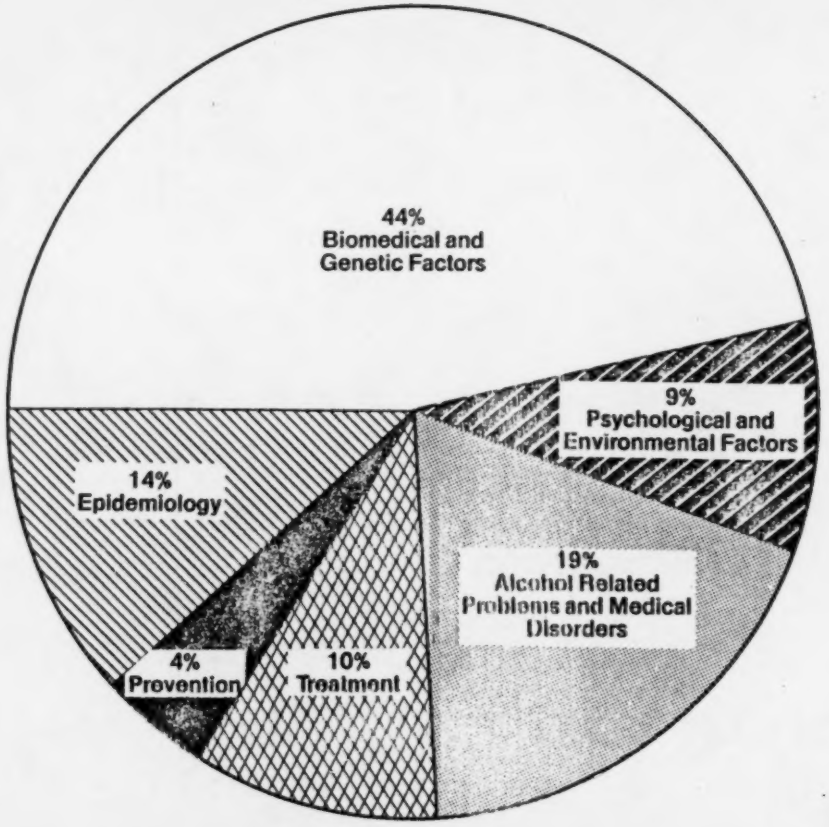
NIAAA
FY 1983 Extramural Research Funds by Major Research Categories



NIAAA
FY 1983 Research and Research Training



FY 1983 National Alcohol Research Centers Funds by Major Alcohol Research Categories



Senator HAWKINS. Thank you, Dr. Niven. We are proud of your work and Dr. Pollin's.

Dr. Pollin, there have been reported disagreements as to the relative importance of supply reduction and demand reduction efforts. Do you have any data to suggest which is most important?

Dr. POLLIN. Yes, Senator Hawkins; we have some data and we have some opinions about that. On the one hand, it is clear that supply reduction can never be totally successful, and that there will always be significant levels of drugs that will continue to come into the country.

But our research data indicates that if a drug like cocaine, and I will use that as an example, were as freely available as cigarettes are today, instead of being used by 4 or 4.5 million people, it would likely be used by as many or more people than use cigarettes. This because cocaine is a more reinforcing drug and its immediate consequences are in some ways less unpleasant to the user than are the immediate consequences of smoking cigarettes.

In our view, therefore, we think it is safe to say that supply reduction, in effect, reduces by 90 percent the potential number of users of drugs such as cocaine or heroin. And so we have, instead of 50 million cocaine users to worry about, 4 to 5 million.

Within that remaining 10 percent which we do not think supply reduction can ever completely eliminate, we are dependent upon demand reduction activities to change attitudes, perceptions, behavior with regard to drugs. Then we think we can reduce that remaining 10 percent, as has happened in recent years.

Senator HAWKINS. Your Institute has reported evidence of a decrease in drug use, as we saw in the chart, yet, we have strong evidence of increased supplies of drugs. Can you explain the contradiction?

Dr. POLLIN. Well, I think it is a more apparent than real contradiction. Part of the reason for increased supply and decreased price—and there have been dramatic decreases, for example, in the price of cocaine—has been the reduction in demand.

There are some powerful laws of supply and demand that are operating in this area as well as elsewhere. And there were tremendous increases in the acreage devoted to the growth of coca and the production of cocaine in South America over the past 2 years.

This, in the face of an actual reduction in the number of people using in this country, has led to there being a glut on the market, in actuality. That is our understanding of how those two fit together.

Senator HAWKINS. I met with Mr. Mortimer, the Commissioner of Narcotics from Hong Kong. Did you meet with him? He was here today?

Dr. POLLIN. No; I have not seen him as yet on this trip. I have met with him in the past.

Senator HAWKINS. Yes. He has a model program, I feel, in Hong Kong, and he told me earlier today that there was a rapid shutoff of heroin in Hong Kong earlier this year and the numbers reporting to the rehabilitation clinics skyrocketed the next day—10,000 additional people during this period of time. They had no source because of the large seizure.

But he said that, when it became available on the streets again, 9,500 of the new people who asked for rehabilitation stayed with the program.

So I just wonder what conclusion you would draw from the Hong Kong experience.

Dr. POLLIN. Well, it seems clear from our own studies in this country, as well as the Hong Kong experience, that if you can involve narcotics addicts in treatment, you will lose some percentage of them, but depending upon the adequacy and quality of treatment, you will retain a significant number of them in treatment. And it is also very clear that the longer they stay in treatment, the better the outcome; and sometimes the outcomes are very dramatic in terms of reduction in use of drugs, reduction in crime, reduction in other consequences of drug abuse.

Senator HAWKINS. He stated that he also saw productivity increases because those in the rehabilitation program were able to go back to work, while if they are on drugs they are unable to work. They encourage them to work and to come to the clinic everyday.

According to your statistics, does work experience have an impact upon use and consumption?

Dr. POLLIN. We think that there is an impact in both directions. On the one hand, providing adequate services to help addicted individuals get back into the workforce has been shown to be a very important part of an effective treatment program.

On the other side of the coin, we are very concerned and rather startled by some of the recent figures when large national concerns have begun to use urine analysis routinely in screening potential employees because the nature of the industry is such that having people who are using drugs would be a particular source of public danger. For example, we are getting reports of between 30 and 70 percent positive findings in large numbers of potential employees in certain transportation industries. That kind of data reinforces the point I tried to make earlier that though, indeed, there has been some useful turnaround in terms of overall levels of use of drugs in this country, the levels of use remain dangerously and unacceptably high.

Senator HAWKINS. What is your personal opinion of using prime time advertising to reinforce the message that we are trying to get through to the young, both to those who are not and to those who are on drugs?

Dr. POLLIN. I think it is very important so long as one chooses wisely the particular medium and the particular communication channel that is appropriate to the subgroup of young people or whatever other subgroup you are trying to reach.

It is clear to us, for example, that if we want to reach certain subgroups of young people, we would do much better to try to get our message on the 10 most successful rock music stations than on some of the evening news broadcasts.

But given an appropriate selection of the medium of communication and an appropriately selected message that has been empirically tested, we think that that is a very important initiative.

Senator HAWKINS. Have you seen the tapes of the Hong Kong commercials?

Dr. POLLIN. Of their public service messages?

Senator HAWKINS. Yes.

Dr. POLLIN. No; we have not. I have not personally as yet; I think some of our staff have.

Senator HAWKINS. I have a copy of that entire program that may be of interest to you. It really was interesting to me to see it in Hong Kong, and then we had that in our last hearing on the role of media in drugs abuse prevention and education.

Today, Mr. Mortimer said that he felt that played as big a role as anything they are doing, and he further went on to say that it does make a difference as to what they say and how they say it. So I am sure your professionalism will bring a downturn in what I think is the No. 1 problem in the country today.

In Hong Kong, for instance, they are down from 400,000 registered addicts to 10,000. That is dramatic, considering their geographic location right in the shipping lanes of every exporter of heroin.

Dr. POLLIN. Indeed.

Senator HAWKINS. So I think that is a very dramatic program, but they do have great reinforcement from the Government and, Mr. Mortimer said, great competition from the networks over who would run this program. So, that shows you that it is watched and very beneficial.

Dr. Niven, your statistics regarding the use of alcohol during pregnancy and its effects on the unborn are always shocking and startling for me to listen to, but particularly when you consider that this is preventable.

Could you tell us what you are doing to disseminate your research findings about the health hazards associated with the consumption of alcohol during pregnancy and how to prevent the complications?

Dr. NIVEN. Yes, I would be delighted to. If you do not mind, I would like to take 60 seconds, though, and not wanting to tread on Dr. Pollin's turf, I would like to make a comment about the Hong Kong experience because I think at least it implies evidence that people do not like to be addicted to drugs.

It is an unpleasant, painful experience to be addicted, whether that drug is alcohol, heroin, or anything else. When you offer these individuals an opportunity for getting better and they can be living a life free of drugs, difficult process as that is to achieve, they enjoy it and they will jump at it. I think I would take that conclusion from that.

Senator HAWKINS. Surely.

Dr. NIVEN. I would agree with your statement that the statistics regarding alcohol use during pregnancy and its effect on the unborn child are indeed startling, and the evidence from our research projects that we are funding almost monthly gives us some more worrisome data.

Over the years, NIAAA has done a lot to try and disseminate our research findings and our recommendations to women who either are, or are at risk of becoming, pregnant. In 1982, for example, we had a large public service campaign which ran for a little over 1½ years and reached many millions of households and many millions of women.

We are in the process of looking at another public service educational campaign directed at women. We are also trying to upgrade our literature and have recently undertaken an effort to distribute some that we have produced on this subject to health professionals. For example, we have mailed booklets and pamphlets describing this syndrome to large numbers of physicians and other health care providers. This is one of several major alcohol-related issues that we are looking at for prevention and research dissemination activities for the next several years because we are the lead agency for the Public Health Service in the 1990 objectives for the Nation in dealing with fetal alcohol syndrome issues.

I would be glad to submit for the record for you in detail those activities that we are engaged in and what our plans are at this time.

Senator HAWKINS. If you would, thank you.

[The following information was submitted:]

ACTIVITIES ENGAGED IN BY THE NATIONAL INSTITUTE ,
ON ALCOHOL ABUSE AND ALCOHOLISM AND FUTURE PLANS

The National Institute on Alcohol Abuse and Alcoholism plans to conduct a survey of practitioners in OB/GYN clinics, pediatric practice, primary health care settings and alcohol, drug abuse, and mental health treatment programs regarding fetal alcohol syndrome/fetal alcohol effects research utilization and state-of-the-art practice. This will help determine opportunities and barriers concerning the widespread application of FAS/FAE-related knowledge. Depending on the results of the survey, NIAAA then will develop new strategies to improve the utilization of these research results.

NIAAA also recently produced and published the Fifth Special Report to the U.S. Congress on Alcohol and Health which includes the latest research findings about fetal alcohol syndrome and fetal alcohol effects and research on prevention programs which have been used to reduce the incidence and prevalence of FAS/FAE. This Report is widely disseminated to researchers, policy-makers, program administrators, health care practitioners, alcohol, drug abuse, and mental health clinicians, members of the clergy, educators, and media representatives. One encouraging finding reported in this update on the research is that many women who usually drink heavily markedly decreased their drinking while pregnant.

The Institute is aware, however, that it cannot give one message, one time, through one mechanism and expect to achieve lasting behavioral changes. Therefore, it will continue its efforts to repeat warnings and stimulate prevention and early intervention efforts. A special effort, therefore, is being made by the Institute in cooperation with the Healthy Mothers, Healthy Babies Coalition operating out of the U.S. Public Health Service.

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NIAAA, with PHS, is collecting and analyzing all FAS/FAE and related materials that have been developed and disseminated by States, national voluntary and professional organizations, clinics, local governments, and so forth. These materials will be assessed for their replication potential and then distributed nationwide either in audio-visual or printed formats. A special mailing of FAS/FAE and women and alcohol materials will be disseminated this Fall to leaders of major women's organizations, health organizations, nutrition groups, neonatal and related-organizations, Ob/Gyn professional associations, and to State alcohol, drug abuse, and mental health prevention specialists. This mailing is expected to result in a ripple effect whereby these leaders will then announce the availability of materials and technical assistance from national, State, and local organizations.

Recently, members of the National Prevention Network--State designees for alcohol and drug abuse prevention--participated in the nationally-declared Fetal Alcohol Syndrome Week. The States, through a variety of mechanisms, including public education campaigns, used this opportunity to repeat and reinforce earlier warnings about FAS/FAE.

Senator HAWKINS. You mentioned the role alcohol played in highway fatalities and its involvement in other types of accidents. You hear a fair amount about the highway fatalities, but would you tell us more about the other accidents that you alluded to which may be related to the use of alcohol?

Dr. NIVEN. Yes. When one looks at accidental and traumatic injury and death—and, actually, deaths from things that most of us do not generally consider to be accidental, like homicide and suicide—there is a statistical association between alcohol use and virtually every kind of traumatic death.

The numbers are worrisome, with the one exception being commercial aircraft accidents. The statistical association of alcohol with such accidents, while not zero, is very, very low, a fact which those of us who fly, including yourself, I am sure, find reassuring.

The data, unfortunately, are not as solid or hard or as comprehensive as we would like them to be. And in most instances, we really do not understand how alcohol interacts with some of the other things that go into producing violent deaths, including accidents. There is a great need to understand this more comprehensively and develop educational and other kinds of prevention programs to minimize this risk.

A recent calculation indicated that, as I indicated previously, about 40,000 of the 100,000 accidental deaths are alcohol related. And another calculation that we did suggested that up to 20 percent of what we call the years of potential life lost—a yardstick by which one can measure the relative effect of certain diseases on morbidity—was related to alcohol; not all of it to accidents, but to all kinds of adverse effects of alcohol.

To deal with this, I have had extensive discussions with Dr. Pollin, with Dr. Williams from the National Institute of Aging, with people from the National Highway Traffic Safety Administration, and with Dr. Mason from the Centers for Disease Control to try and develop a program of research, research dissemination, and examination of a variety of policies to first better understand and then do something to prevent this toll that alcohol and other drugs takes. Data for drugs, like marijuana and cocaine, also suggest that, in many instances, they can be involved in the same kinds of accidental injuries and death as alcohol.

Senator HAWKINS. Alcoholism seemed to be a disease to which a stigma has been attached, but I think I see this changing over the years from my vantage point. Can you tell us why?

Dr. NIVEN. Well, I would certainly agree with you that it has been changing. It is a good change from our standpoint because things like alcoholism, for which there is a stigma, are hard to understand. It is hard to identify and appropriately treat the people who are thus stigmatized.

I think, in fact, that is one of the reasons why women who do have alcoholism do not seem to have the same kind of access to treatment programs as their male counterparts. One possible explanation for that, and I think it is a valid one in some instances, is that there is more stigma attached to being an alcoholic in our society if you are woman than if you are a man.

I think that differentiation in stigma, if you will, is declining, but I think there is that stigma. We would like to think, and I do think

to some extent, that the tremendous amount of work that NIAAA and other people who have been concerned about alcoholism, including people recovering from it, have been instrumental in diminishing the stigma over the years through our educational efforts.

I think the research that the Federal Government has funded and the findings from that research have done a lot to help us prove that you can indeed recover from alcoholism; that it is a treatable and, in many instances, preventable problem. I think research has helped diminish the stigma.

Senator HAWKINS. We also have a lot more people, I feel, of star quality who now are very actively outspoken in AA, Alcoholics Anonymous, and make great sacrifices of their personal time, I think, across the country giving speeches and also making commercials, which I think is very reinforcing.

Dr. NIVEN. I completely agree with you. I think that people who have made their alcoholism known, who are public figures, who attract that kind of attention, add a lot of credibility and have done a lot to make this more understood, more acceptable, and a less frightening problem.

Senator HAWKINS. And some consider it a disease rather than a habit. Is it?

Dr. NIVEN. Yes, absolutely; alcoholism is a disease. There are many people who have adverse consequences of alcohol use in their life who do not have alcoholism, and I am not saying that all the problems associated with alcohol use are a disease, but alcoholism is a disease.

Senator HAWKINS. You mentioned in your statement worksite performance impairment. Could you elaborate on this and why you believe that sustained, enhanced education is needed for physicians and other health care providers?

Dr. NIVEN. I think worksite performance and all kinds of human performance are impaired by alcohol and by other psychoactive drugs. Our concern is two-told. First we need to enhance our understanding of the exact role that alcohol plays on the worksite, including the home, which is a very pervasive worksite in this country and a place in which there is a lot of accidental injury and death. Second, it is important to educate physicians, other health care personnel, and management and supervisory personnel about the role that alcohol and other drugs can play in impaired performance, whether that is associated with a safety issue or simply decreased productivity. We believe this is very important in helping us diminish, not only the mortality and the morbidity, but also the costs to our society associated with alcohol and other drug use. Most physicians and other health care providers simply are not sensitized enough to these problems. Even when they are sensitive enough, they sometimes just do not have the necessary level of understanding or of skill to do something about somebody's impairment, whether it is from alcohol or other drugs.

Senator HAWKINS. In your opinion, does the media glamorize the issue of alcohol?

Dr. NIVEN. I think unfortunately it is very easy for all of us—collectively and individually—to get into circumstances in which we inadvertently can glamorize or condone what we in this field

call "enabling behaviors" that turn out to be adverse behaviors or nonproductive. I think, in some instances, that indeed has happened in all of the media. I think it is not a planned, conscious effort, but I think it happens all too readily. I think the media has become quite sensitive about that and has begun to develop programs to deal with it.

Senator HAWKINS. Yet, I have not heard too much about their programs changing, especially their daytime programs. I was in traction the other day for several hours and unable to turn off the tube, which was over my head. I cannot tell you how many times a door opened and characters were offered a drink in a situation of a daytime soap, I guess they call it. It surely was lurid, but it was during work hours.

It was a program that the nurses tell me they all run down to the nurses' station to watch at a certain time everyday. But in the different scenes I counted, how many times—it was just, "how are you; come in; can I fix you a drink?" It was just like it is taught at Emily Post that this is the way you welcome guests to your home or apartment or wherever it was.

That is what is sticking out in my mind: that those of us that do not open the door and say, "I am so glad you made a call, would you like a drink," feel that we may not be executing our full social duty.

Dr. NIVEN. I agree with you, especially when you consider the fact that approximately one-third of the adult population of this country does not drink at all or on exceedingly rare occasions, and another third drinks very sparingly. I think that kind of depiction does not accurately reflect normative drinking practices in this country.

Senator HAWKINS. Well, I understand it happens on the Hill, too. I have been conducting a private survey and it is interesting how many people this interests. With our many other problems in the world today, I just could not believe this was going on, but I have become a believer.

I thank both you gentlemen for the great job you do and for helping us with this problem. I am looking forward to working with you, especially in the prime time and women's issues. I am sure that they will bring forth some statistics that we have needed for a long time. Thank you both for your dedication.

Dr. NIVEN. Thank you.

Dr. POLLIN. Thank you, Madam Chairman.

Senator HAWKINS. Our next witness will be Thomas Kirkpatrick, Jr., who is president of the National Association of State Alcohol and Drug Abuse Directors, NASADAD.

Let us have all three as a panel. As I understand it, that will be Linda Pasternak, who is the president-elect of the National Association of Alcoholism Treatment Programs, and Sheila Blume, a member of the board of directors of the National Council on Alcoholism.

We welcome you here and ask for brief statements starting with Mr. Kirkpatrick.

STATEMENT OF THOMAS B. KIRKPATRICK, JR., PRESIDENT, NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS; LINDA J. PASTERNAK, PRESIDENT-ELECT, NATIONAL ASSOCIATION OF ALCOHOLISM TREATMENT PROGRAMS, INC.; AND SHEILA BLUME, MEMBER, BOARD OF DIRECTORS, NATIONAL COUNCIL ON ALCOHOLISM

Mr. KIRKPATRICK. Thank you, Madam Chairman, for the opportunity. With your permission and in the interests of your time, I would like to submit our prepared statement for the record and orally to highlight some of our major concerns, and thereby allowing the other panelists time also to present their feelings to you.

The National Association of State Alcohol and Drug Abuse Directors, of which I am the president, represents the 50 States' alcohol and drug abuse single State agencies who have and continue to provide the bulk of treatment and prevention services for alcoholism and drug abuse in the United States.

With the elimination of Federal requirements that there be such agencies, it is refreshing to know that all of the States have decided to keep those agencies in place and, in fact, are the front line of provision of services at this time.

I also am a member of the National Drug Abuse Advisory Council, which is to advise Dr. Pollin's agency on policy, and was previously on the President's Strategy Council for Drug Abuse, so I have been involved with the institutes at the national level and that is why I would like to address my comments to the legislative proposals for the reauthorization of the institutes and for requirements and directions and guidance for those agencies in the next few years.

We support the 3-year authorization of the institutes. We are a little concerned about the amount of increase in the second and third year, which is anticipated to be at approximately, say, a 4-percent level or in that area, and we would think that given the continuing emergence of the problem and the public consciousness and demand that something be done, probably a 10- to 15-percent increase in the second and third years would be more appropriate.

We believe that the research that is put into alcoholism and drug problems should be commensurate with the research in terms of money that is put into other major diseases. I think as the previous witnesses testified, alcoholism and drug abuse are the No. 1 health problems in this country.

And if you were to add all of the costs of not just health care, but the social costs and the criminal costs and the domestic violence and the child abuse, the costs are staggering and in the billions of dollars.

Consequently, it is a good investment up front to put money into finding the solutions to dealing with these problems, at least as much as we do for cancer and for heart disease and eye disease, and so forth, because one of the characteristics of alcohol and drug problems is that they can be cured and that you can make a difference if you have the right tools.

We are concerned about the direction research has taken in the institutes and what its direction is for the future. The National Drug Abuse Advisory Council, for example, has passed a resolution

unanimously requiring NIDA to increase the amount of money that goes into prevention research by 10 percent each year until it reaches a level that is commensurate with other areas of research.

It has been a growing concern among the States that we have research which is practical, which is useful, and which can be applied in the field to be turned into something useful to us to provide treatment and prevention services.

In effect, we have recommended that of new research money that is made available to the institutes, 50 percent or half of it be set aside for applied research in the treatment and prevention area. This ties in nicely with your mentioning of a proposal earlier to put some demonstration money available to the institutes to show useful models that we can do something with now.

I am not criticizing; in fact, we support wholeheartedly the biochemical and biomedical research that is being done by the institutes. But for those of us who are providing services to thousands of clients everyday—and at the State level we have that responsibility—we need to have research that can be translated into something useful to us and to those clients awaiting treatment and to those people whom we might prevent from needing treatment today. So we are urging some consideration of that request.

With regard to the special needs of women in alcoholism and drug abuse treatment and prevention areas, I personally support that wholeheartedly, as well as our organization. I am a charter member of the Illinois Women's Substance Abuse Coalition.

We have tried for years to get a special residential program started for women with children to preserve the family, at the same time providing the treatment that is needed. We have an excellent program for pregnant addicts in Chicago, but the cost runs as much as $40,000 a year to treat a pregnant addict through the full term of pregnancy. It is a very successful program.

Most of the addicts who come there, their first thought is to have an abortion or to get rid of the baby. But 90 percent of them end up keeping the baby and raising it and breaking their own addiction as well. But the State certainly cannot afford the $40,000 fee. We also had a legal case in Illinois recently where the judge has ordered the State to take custody of the fetus because the mother is addicted.

Now, that is going to raise some tricky legal problems, but it has brought a lot of public attention to what it costs to treat as yet unborn babies who are going to have a dependency problem. This is in addition to the well-known problems of fetal alcohol syndrome. Legislation has been proposed in our own State to require a public notice at every possible point of purchase of alcohol, whether it is a tavern, a liquor store or a grocery store, containing warnings on fetal alcohol syndrome.

Just a couple of other items. There is a requirement for development of a national alcoholism plan, and we feel that if you are going to develop an alcoholism plan it should be comprehensive and include other drugs as well.

Forty-one of our States have combined their alcohol and drug agencies. My own State combines ours on July 1 of this year. The need at the Federal level for similar cooperation, especially in the areas of prevention, for example, where you can deal with alcohol-

ism and drug issues very neatly and together and not artificially separated, is important. So we feel that the plan would not be comprehensive unless it included both.

The need for data collection is important. Since there are no more requirements on Federal funds that require you to report uniform data from each State about the nature of the clients served and what happened to them and the nature of expenditures and the extent of services, each State has gone its own way in trying to develop a system that meets its own State's needs. As a result there is no longer a national comprehensive system that collects data about drug and alcohol problems, about the services that are provided, about their effectiveness.

And there is a very big danger in using isolated surveys and examples. For example, the two surveys that were mentioned by the directors previously concerning high school attitudes and high school use—they sometimes present a distorted picture if there is not a total national picture of what is happening.

In our own State, we have had a 400-percent increase in the number of people seeking help for cocaine problems within the last few years, and it is still going up; a 100-percent increase in cocaine.

Just because 1,500 students were surveyed who said that drugs were a major cause of problems for kids does not mean that there is less of a problem with drugs even among those same 1,500 kids. At the same time they answered that question, they also made the distinction that they do not have a problem.

Half of the difficulty in dealing with alcoholics and drug addicts and drug-dependent people is getting them to admit their own problem. People ask me many times, for example, when a famous person dies—when John Belushi died—well, will that not discourage kids? No, not at all. They all make their own excuses and say, well, he could not handle it; I can handle it. He mixed it this way; I do not do that. There are a million excuses why.

So I would be skeptical of isolated surveys. We need a comprehensive picture of what is really going on in the country, and we need the institutes to support that in conjunction and cooperation with the States.

We also need the dissemination of information, and you have quite rightly pointed out that we need to get the message into prime time. We applaud that. My only concern is that, as you rightly pointed out, the bombardment by the entertainment media, whether it is intentional or not, to create an atmosphere in which use, abuse, misuse of alcohol and drugs is an integral part of success, of style, of celebrity, is tremendous.

I do not know how many prime time commercials it would take to overcome that because they come to us from all directions. Anything we can do to counteract it, we support. My only question is there must be more ways to add to that because it is going to be a very rough mountain to climb to overcome that constant social pressure.

We need the dissemination of the research findings that have come over the last years. The millions and millions of dollars that have been spent need to be disseminated not only widely, but in a form that is understandable, useful, and can be put into practice as

soon as possible because that is where research pays off in the long run.

That concludes my brief comments and I will be available now or at the conclusion of this panel for questions.

[The prepared statement of Mr. Kirkpatrick follows:]

TESTIMONY OF

THOMAS B. KIRKPATRICK, JR.

PRESIDENT
NATIONAL ASSOCIATION OF STATE ALCOHOL
AND DRUG ABUSE DIRECTORS

and

DIRECTOR

ILLINOIS DANGEROUS DRUGS COMMISSION

before the

SUBCOMMITTEE ON ALCOHOLISM AND DRUG ABUSE
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

on

REAUTHORIZATION OF THE
NATIONAL INSTITUTE ON DRUG ABUSE
NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

May 1, 1984

Dear Chairman and Members of the Subcommittee:

Mr. Chairman, I am pleased to appear before the Subcommittee on Alcoholism and Drug Abuse today on behalf of the National Association of State Alcohol and Drug Abuse Directors (NASADAD). NASADAD is a non-profit organization whose membership is comprised exclusively of the officially designated State agencies for alcoholism and drug abuse treatment and prevention. As President of NASADAD I am hear today to urge members of the Subcommittee to continue to support the important data collection, information dissemination and research activities being conducted by the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). I am intimately involved with the activities of the Institute, not only as a State Director but also by virtue of my current seat on the National Advisory Council on Drug Abuse. Before I provide specific comments on the NIAAA and NIDA programs, I would like to provide you with some background information on the State Alcohol and Drug Abuse Agencies.

STATE ALCOHOL AND DRUG ABUSE AGENCIES

The State Alcoholism Agencies and the Single State Agencies for Drug Abuse Prevention were created by the States in response to Congressional action in the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act of 1970 and the Drug Abuse Office and Treatment Act of 1972, respectively, to have sole responsibility in the States to plan and administer a Statewide alcoholism and/or drug abuse prevention and treatment network.

Under the Omnibus Reconciliation Act of 1981, which created the Alcohol Drug Abuse and Mental Health Services (ADMS) Black Grant and significantly revised the purpose of NIAAA and NIDA, the mandate for Single State agencies was repealed. However, I am pleased to inform you each State has chosen to retain this

State structure in order to effectively coordinate State alcohol and drug treatment and prevention services including administration of the relevant portion of the Federal ADMS Block Grant.

STATE-FEDERAL RELATIONSHIP

The State Alcohol and Drug Agencies have always had a strong working partnership with NIAAA and NIDA. This relationship was initially one in which the Federal Government provided national leadership and stimulated State and local government participation in the development of a well-coordinated and comprehensive alcoholism and drug abuse service delivery system. Although the Federal-State partnership has been preserved over the past two decades, the role each level of government plays has changed dramatically over the years.

When the Federal-State partnership was formed, most State alcoholism authorities and State drug abuse agencies were generally small, had limited authority and low visibility within their State government. State and local financial support of community based service programs was minimal or non-existent. In the past decade the States have assumed an ever increasing role in the administration and monitoring of not only State and local revenues but also the Federal categorical monies awarded for the support of alcohol and drug prevention and treatment services. When ADMS Block Grant program was authorized in 1981, the States assumed total responsibility for the administration of these Federal treatment and prevention monies.

In conjunction with the authorization of the ADMS Block Grant, the Institutes' mission underwent a major transformation. Whereas the Institutes' previous emphasis had been jointly placed on the services and research programs, after the ADMS Block Grant was authorized the research

programs became the major focus of NIAAA and NIDA. The national clinical training programs were also dismantled due to lack of funding support from the Administration and Congress. The comprehensiveness of the NIAAA and NIDA data collection efforts were also negatively impacted due to the elimination of Federal reporting requirements as a condition of receipt of Federal funds. Throughout this major transformation, however, the Institutes' information dissemination efforts were continued and the importance of these efforts were emphasized by the Congress.

REAUTHORIZATION OF NIAAA AND NIDA

The Institutes current research authority expires on September 30, 1984. Although a bill to reauthorize the Institutes has not yet been introduced in the Senate, it is my understanding that the Chairman is in the process of developing the legislation. If I may I would like to offer my recommendations for legislative provisions related to the reauthorization and comment on several provisions which the Chairman is reportedly considering.

PERIOD OF AUTHORIZATION AND FUNDING LEVELS

NASADAD recommends that the Institutes be reauthorized for a three year period. A three year authorization would provide needed continuity and stability for Institute programs. The funding levels reportedly under consideration by the Chairman match the President's budget request for these programs in FY 1985 with a four percent increase in each of the remaining years. NASADAD applauds the Chairman's consideration of the authorization levels as proposed by the

President which permit increases in the NIAAA and NIDA research programs for FY 1985. We, however, would urge the Chairman to propose authorization levels for subsequent years that would allow a 10-15 percent increase for these programs. We hope funding levels will ultimately reach a level commensurate with the research support provided for other serious illnesses, such as cancer. Although the research programs, NIAAA's in particular, have received increased financial support from the Administration and Congress in recent years, there is still significant room for growth and it would not be appropriate to cap them at the FY 1985 levels.

NEED FOR BALANCE BETWEEN BIOMEDICAL AND TREATMENT AND PREVENTION SERVICES RESEARCH

During the January 25-26, 1984 meeting of the National Advisory Council on Drug Abuse, a report presented by the Prevention Subcommittee of the Council which is chaired by Dr. Lloyd Johnston, University of Michigan, concluded that while NIDA is supporting a number of important prevention research projects and initiatives the level of funding for prevention is considerably below the need and should constitute a larger proportion of NIDA's budget. Subsequent to Dr. Johnston's Subcommittee report, the Council passed a rather lengthy resolution which had six major points including, but not limited to the following: from its current level of approximately 7.8 percent of NIDA's budget, the resources allocated for prevention research should be increased by 10 percent per year over the next five years. NASADAD would like to go one step farther than the Council and recommend that 50 percent of all new research monies be allocated for the conduct of applied research on treatment and prevention services, including research on the cost-effectiveness of alcohol

and drug treatment modalities and prevention approaches.

There currently exists a great imbalance between support for biomedical versus other research within the Institutes. While we do not advocate that any of the current biomedical research is unworthy of support or will not ultimately lead to improvements in the fields of alcoholism and drug addiction and abuse, we do advocate that research on treatment and prevention services is not being supported at a level commensurate with its importance and value to the local service provider. Since we would be inflicting damage on the current biomedical research being conducted by the Institute if we proposed that 50 percent of all research monies be given to the investigation of treatment and prevention services, we simply ask the Subcommittee to recognize this imbalance and direct that any new monies be allocated equally between biomedical and practical, applied research on services. The following areas of research would provide practical information to the treatment and prevention communities, including: how treatment efficiency can be increased without sacrificing quality; a determination of which treatment approaches are most appropriate for what particular types of clients; studies of the non-treatment factors which may be related to recovery; studies of the treatment problems of the dual-addicted person and effectiveness of K-12 school based prevention approaches and community prevention/education efforts.

RESEARCH ON WOMEN

NASADAD also fully supports the separate authorization of one million dollars per Institute per year for three years for the conduct of research on the alcohol and drug abuse prevention and treatment needs of women. S. 2146,

the Prevention and Treatment of Alcoholism, Alcohol Abuse and Drug Abuse Among Women Act of 1983, as proposed by the Chairman and Senator Hatch includes this specific provision and we would request that it would be included in the Chairman's reauthorization proposal for the Institutes.

COMPREHENSIVE NATIONAL PLAN

It is my understanding that the Chairman is considering the inclusion of a requirement for the Secretary of the Department of Health and Human Services to transmit to the Congress a comprehensive plan to combat alcohol abuse and alcoholism. While I applaud your consideration of this provision, I would recommend that this requirement require the development of a national alcohol and drug abuse plan. I feel a combined alcohol and drug abuse plan would be much more relevant for the contemporary treatment and prevention setting in which a significant portion of clients, particularly within the youth population, abuse both alcohol and drugs. The combination of alcohol and drug abuse planning, treatment and prevention systems is something which has occurred at the State level for over a decade. Currently 41 States, Puerto Rico and the U. S. Territories have a combined alcohol and drug agency. In my State of Illinois, where we had separate alcohol and drug agencies for many years, a combination of the two agencies will take place on July 1 of this year.

DATA COLLECTION AND EPIDEMIOLOGY

NASADAD believes it is crucial for the NIAAA and NIDA data collection and epidemiology programs to be fully supported by the Congress. As I mentioned earlier

the Institutes previously collected information from the State and local programs as a condition of receipt of Federal funds. These data collection efforts focused on alcohol and drug treatment and prevention services and on the clients which received these services. While NASADAD is working on a cooperative, voluntary basis with the Institutes to collect already existing information from the States particularly on services, the Institutes' comprehensive client-oriented data efforts are not faring as well. Even though States do not wish to return to the days of extensive mandated reporting requirements which collected data - the value and usefulness of which was at times questionable - the States and Institutes currently need support for the development of a mechanism and process by which significant data can be compared with other States across the nation or even within their own region. We would like the Institute to assist us with our efforts and applaud the Chairman and Senator Hatch's inclusion of such a provision in the ADMS Block Grant reauthorization bill, S. 2303. States have become increasingly concerned over the lack of data available at the national level which comprehensively and accurately describes the treatment and prevention network and its clients. While a considerable amount of data was collected by NIAAA and NIDA prior to the beginning of Fiscal Year 1982, only limited data has been collected since that time period. In the meantime, States have sought to revise their data collection systems to make them more responsive to their individual needs. As a result, the ability of States to compare information based on the same data elements and definitions is being threatened. As responsible State officials we believe that a uniform data collection tool process should be jointly developed and implemented by State and Institute representatives. Some of these

data elements that should be incorporated into this instrument include the following: information on total numbers of clients served by different types of programs; information on client needs, demographic characteristics and services; information on types and levels of fiscal resources utilized to support prevention, intervention and treatment services; information on emerging and special needs (e.g., women, youth, drunk drivers); information on the effectiveness and impact of treatment and prevention programs.

NASADAD looks forward to working with the Congress and the Secretary in whatever way we can to assist in the development of a model instrument and process which will help the alcohol and drug fields to better assess the alcohol and drug abuse service delivery systems and their clients. I encourage the Chairman to give her full support to the NIDA and NIAAA data collection and epidemiology programs.

INFORMATION DISSEMINATION ACTIVITIES

NASADAD applauds the Subcommittee's emphasis on the need for the immediate and straight forward dissemination of newly acquired information on alcohol and drug abuse.

Information dissemination is perhaps one of the most important functions which the Federal Government undertakes for the public. While we can seek the development of new information on alcohol and drug abuse, it is of limited use unless it is disseminated to the public, and disseminated in a fashion which will permit service providers and ordinary citizens to understand the implications and value of the information.

It is my understanding that the Chairman is considering providing the Institutes with the authority to develop public service announcements which will translate research findings into easily understandable messages. I applaud the Chairman for this initiative and continued recognition of the importance of information dissemination activities.

In closing, I would like to thank the Chairman and members of the Subcommittee for their dedication and understanding of the tragic illnesses of alcoholism and drug addication. Indeed, no one is immune from the tragic problems associated with these illnesses. I would be happy to answer any questions which you may wish to present.

Senator HAWKINS. Thank you.

Ms. Pasternak.

Ms. PASTERNAK. Thank you, Madam Chairman. I am Linda Pasternak and I am executive vice president of St. John's Hospital, a speciality hospital for the treatment of alcoholism and chemical dependency in Richmond, VA. I appear before this committee today in my role as president-elect of the National Association of Alcoholism Treatment Programs.

NAATP represents more than 350 private sector programs throughout the United States, comprising both for profit and nonprofit hospital based and freestanding, including the Bowling Green Inns, out of St. Petersburg, Comprehensive Care Corp., and Brookwood Lodges, to name a few.

Before beginning my testimony on behalf of NAATP and the renewal of legislation for NIAAA, I want to express our association's congratulations to you, Senator Hawkins, at your recent assumption of the chair of the subcommittee. Our association is delighted to have a subcommittee dealing specifically with the issues of alcoholism and chemical dependency and, more importantly, believe we will benefit from sensitive leadership of you and your staff.

For the past 13 years, NIAAA has been the forerunner in alcoholism research and prevention, and under Dr. Niven's stewardship NIAAA is confidently approaching a more comprehensive and elaborate research model.

Alcoholism is estimated by the Institute to be the third leading cause of death and disability in the United States, trailing only heart disease and cancer in its magnitude. For several years, NIAAA has given the same disturbing statistic. Eighty-five percent of the people in need of treatment never seek or receive that treatment.

Untreated alcoholism, its ravaging effects devastating nearly every organ in the system and the body, is indeed today's American tragedy. However, alcoholism is an illness which can respond to appropriate treatment. Many of the modern treatment techniques are the direct result of NIAAA's research and meaningful observation of the state of the art.

Since the inception of the alcohol, drug abuse, and mental health block grant, NIAAA is no longer involved in funding of direct treatment services. The Institute's role is now, as Dr. Niven mentioned, that of a research agency.

The private treatment sector welcomes this role for NIAAA, for despite the many positive advances in our field as a result of the Institute's research, there is far to go before we achieve a depth of understanding of this disease comparable to its magnitude.

The Institute is in a position to expend greater, nonvested effort in the area of treatment assessment research. We support the Institute's many outstanding biomedical and psychosocial research efforts, but feel that the treatment assessment and efficacy area has been historically underemphasized.

The public and the treatment field need more useful data and analysis of alcoholism treatment in order to generate more appropriate treatment for more individuals. Members of our association are dedicated to the concept of levels of care in alcoholism treatment. This concept needs to be recognized, researched, and refined with assistance from NIAAA.

Just as there are many types of cancer and many types of heart disease, we believe that there are multiple types of alcoholism and alcoholics. There are several variables in diagnosis and treatment, including age; gender, as has been mentioned here today; drinking history; family history; previous treatment; medical condition; and motivational factors.

To deal with these different types of treatment factors, the field has responded with three basic modalities or levels of care: inpatient, residential, and outpatient treatment. However, there is currently little agreement as to which level of care is appropriate to which kind of alcoholic.

Last year, the Office of Technology Assessment issued a report entitled "Effectiveness and Costs of Alcoholism Treatment." This report concluded that it costs more not to treat alcoholism than to treat it. Nevertheless, the report underscored the fact that there is a notable lack of methodologically sound treatment assessment and evaluation research in alcoholism.

This leaves many questions unanswered. The basic question, of course, is this: what type of treatment is appropriate for the patient? And in the absence of sound research, that question becomes more imperative to answer.

In response to the problem OTA, with the support of our association, called for research on the creation of an agreed-upon patient placement system which would match patients to the appropriate level of care.

Agreeing with this concept, the Senate Appropriations Committee instructed the Institute to initiate such an effort in earnest. To date, there appears to be a literature search in progress. However, in OTA's opinion, the literature in question may be of dubious value.

We suggest that the Institute redouble its efforts in research and ensure that its treatment assessment and evaluation efforts are of sound methodological quality. In the absence of such research, the choice of level of care in alcoholism treatment falls somewhere between a shot in the dark and a decision based solely on costs.

We must guard against imposition of public policy when such policy is not based on careful research. This is particularly true now in alcoholism treatment, where only recently has the illness become more than a dangling appendage to the health care system.

We in the alcoholism treatment field are prepared and anxious for this era of health care costs containment because of our firm belief that alcoholism treatment stands as its own cost containment effort. This is undeniably so in comparison to the never-ending costs of the many consequences of untreated alcoholism.

It is therefore essential that NIAAA maintain its responsibility to disseminate accurate data on treatment effectiveness and cost efficiency, as such data has a direct impact on private insurers.

Currently, insurance coverage for alcoholism treatment is largely available to inpatient, hospital-based programs, while it is scanty at best in residential treatment and nearly nonexistent for outpatient treatment. This is contrary to both health care cost containment efforts and sound treatment practice, and is directly traceable to the lack of well defined, methodologically sound treatment assessment research.

Another indication of the need for more research on alcoholism treatment was the recent decision by the Department of Health and Human Services to grant a temporary exemption from the medicare prospective payment system to alcoholism treatment providers.

We wish to publicly thank Secretary Heckler and Dr. Davis in HCFA for their strong leadership in this exemption. The exemption was certainly warranted because due to inadvertent statistical flaws, the prospective payment rate for alcoholism treatment under medicare would be only 8.1 days. We have until the exemption's expiration date of October 1, 1985, to create an adequate, workable, and realistic DRG structure for alcoholism and chemical dependency treatment.

As the lead Federal agency on alcoholism research, it is crucial that NIAAA become involved in this evaluative, devisive process for appropriate prospective payment. Here again, the absence of reliable data spawned a nearly disastrous result. NIAAA is in the very best position to develop the type of data which the Health Care Financing Administration requires to proceed.

It is of great concern to our association that a contract is about to be let by the National Institute on Mental Health to develop DRG's for alcoholism treatment and there is no mention of any role for NIAAA. How can the lead Federal agency for research on alcoholism be left out of such a crucial effort? Why indeed is advising HCFA on the development of an appropriate DRG for alcoholism treatment not the sole province of NIAAA?

This unacceptable turn of events bespeaks a critical lack of policymaking authority within the Government for NIAAA. If the Institute is indeed the lead agency within the Government for alcoholism, then it must have the authority we believe is necessary to exert that leadership.

Witness, for example, the contradiction inherent in, on the one hand, NIAAA supporting alcoholism treatment, and on the other the Office of Personnel Management unilaterally eliminating alco-

holism benefits for more than 9 million Federal employees, retirees, and their dependents.

Meanwhile, despite NIAAA's data supporting the notion that the average length of stay for treatment is 28 days, DRG regulations stated that it can be done in a mere 8.1 days, which at first was very critical to the development of a DRG stat and now has been rescinded.

It cannot be overstated that adequate research needs to be the basis of responsible public policy. As the lead Federal research agency on alcoholism, NIAAA needs a concomitant role as the lead policymaker within Government. Without such a role statutorily mandated, other agencies, even those within the same department, will continue to operate within a vacuum.

My final point I wish to make this afternoon regards the association's belief in the need for greater private sector treatment field input to NIAAA. The alcoholism field is fortunate to have as the Director of NIAAA Dr. Robert Niven, as Dr. Niven has delivered bold and thoughtful leadership to the Institute and to the field in his comparatively short stewardship.

Dr. Niven comes to the Institute with a background, as you well know, in treatment as well as research, and we applaud that. But, clearly, as the provider of the bulk of alcoholism treatment in this country, the private sector has much to offer the Institute, and as the Institute moves toward a greater effort in treatment assessment research, we believe that an attitude should be created for a formal dialog between the Institute and the treatment providers.

NIAAA's policies are guided by its National Advisory Council on Alcohol Abuse and Alcoholism, a body created by statute and chaired by the NIAAA Director, and composed of representatives of the alcoholism field. We note, however, with regret that there is currently no representative of the private treatment sector on the NIAAA's Advisory Council.

NAATP, our association, believes that a slot on the Advisory Council must be statutorily reserved for a representative in the private treatment field in order to facilitate that dialog.

In conclusion, NAATP wishes to express its support for the continuation of NIAAA and at the very highest level of authorization. The many contributions of the Institute in research, prevention, and treatment of alcoholism have been crucial to our ability to better deal with the widespread problem we are confronted with.

We wish to see expanded Governmentwide policymaking authority for the Institute, accompanied by a greater emphasis on treatment assessment, efficacy, and evaluation research. We urge that the Institute both formally and informally seek greater input from the private sector and that it specifically become involved in the creation of a very important adequate DRG for alcoholism treatment.

This concludes my statement and I will be more than happy to answer any questions you might have.

[The prepared statement of Ms. Pasternak follows:]

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NATIONAL ASSOCIATION OF
ALCOHOLISM TREATMENT PROGRAMS, INC.

Statement

of the

NATIONAL ASSOCIATION OF ALCOHOLISM TREATMENT PROGRAMS

Linda J. Pasternak, President-Elect

before the

LABOR AND HUMAN RESOURCES SUBCOMMITTEE

on

ALCOHOLISM AND DRUG ABUSE

U.S. SENATE

Hon. Paula Hawkins, Chairwoman

on

Renewal Legislation for the

National Institute on Alcohol Abuse and Alcoholism

May 1, 1984

2082 Michelson Drive Suite 200 Irvine, CA 92715 (714) 975-0104

The National Association of Alcoholism Treatment Programs, Inc. (NAATP) appreciates this opportunity to address the Labor and Human Resources Subcommittee on Alcoholism and Drug Abuse, regarding the reauthorization of operations for the National Institute on Alcohol Abuse and Alcoholism (NIAAA). NAATP, founded in 1978, is the only national health care organization solely devoted to issues in alcoholism treatment. NAATP represents the concerns of some 350 private sector programs throughout the United States, both for-profit and non-profit, hospital-based and free-standing, offering inpatient, residential and outpatient treatment regimens.

For the past thirteen years, NIAAA has been the focal point within the federal government, for advancement of alcoholism research, prevention and treatment. Since its inception in 1971, NIAAA has played a crucial role for the alcoholism field, as well as for society as a whole. Many of the seminal inroads we have made in dealing with alcoholism have been direct results of findings made possible through NIAAA-funded research.

Alcoholism is estimated by the Institute to be the third leading cause of death and disability in the United States, trailing only heart disease and cancer in its magnitude. For several years, the Institute has declared the same, disturbing statistic: 85% of people in need of alcoholism treatment never seek or receive that treatment. Untreated alcoholism--its ravaging effects devastating nearly every organ and system in the body--is, indeed, today's "American Tragedy." Perhaps the greatest tragedy is that through modern techniques, constantly being researched and refined, alcoholism is a disease which is eminently responsive to appropriate treatment. Many of these modern techniques, again, are the direct result of the efforts of NIAAA, gleaned through sound and meaningful research.

Since the inception of the alcohol, drug abuse and mental health block grant, NIAAA is no longer involved in funding of direct treatment services. The Institute's role, now, is that of a research agency. The private treatment sector welcomes this new role for NIAAA, for, despite the many positive advances in our field as a result of the Institute's research, there is far to go before we achieve a depth of understanding of this disease comparable to its magnitude.

The Need for Treatment-Oriented Research

For several years, and even with the expanded research

authority which the Institute enjoys now, NIAAA's research efforts have been concentrated in the biomedical and psychosocial areas. This is an emphasis which NAATP supports and which should be continued. There is still much to learn and apply with regard to the effects of excess alcohol consumption on the body, the interaction of alcohol and other drugs, the etiology and epidemiology of the disease, and worthwhile, effective prevention and education techniques.

With the dramatic shift in the majority of alcoholism treatment funding from public to private sources, the Institute is in a position to expend greater, non-vested effort in the area of treatment assessment and evaluation research. This has, historically, been an under-emphasized research area at the Institute, deserving of greater attention. The treatment field and, certainly, the public, need more useful data and analysis on alcoholism treatment, in order to generate more appropriate treatment for more individuals.

For many years, alcoholism treatment has been offered mainly on an inpatient basis in a hospital setting. One of the reasons that this particular modality has prevailed is that most private insurance coverage for alcoholism treatment has pertained entirely to hospital-based settings. Nevertheless, and as Members of the Subcommittee know well, there exist a variety of approaches, settings and modalities for the treatment of alcoholism. NAATP members are dedicated to the concept of "levels of care" in alcoholism treatment. This concept needs to be recognized, researched and refined with assistance from NIAAA.

Just as there are many types of cancer, and different types of heart diseae, there are, as well, multiple types of alcoholism and alcoholics. The variables, in diagnosis, can relate to gender, age, drinking history, family impact and history, employment (history and type), previous treatment experience, overall physical condition, motivation to recover, etc. To deal with the different types of alcoholism, the field has developed three basic modalities, or levels, of care: inpatient, residential and outpatient treatment. Though there are variables on these three types of programming, the basic delineation still applies.

The inpatient level of care is usually best for the severely sick, long-drinking alcoholic, who generally presents for treatment with concomitant psychiatric and medical complications, and who needs absolute separation from the

trappings of everyday life. The residential level of care is an intermediate one, less medically-intensive and, thus, appropriate for patients not experiencing severe medical complications, but who still need the benefit of a therapeutic milieu. Outpatient programming can be appropriate when the alcoholic is in the very early stages of the disease, and whose dysfunction has not become entirely unmanageable.

Last year's report by the Office of Technology Assessment (OTA), "Effectiveness and Costs of Alcoholism Treatment," eloquently concluded that "...it costs more not to treat alcoholism than to treat it." Nevertheless, the report underscored the fact that the notable lack of methodologically sound treatment assessment and evaluation research in alcoholism leaves many questions unanswered. The basic question, in the absence of sound research, remains: What type of treatment is appropriate for whom? In response to this problem, OTA, with the support of NAATP, called for research on creation of an agreed-upon patient placement system, matching alcoholics to the appropriate level of care based upon the severity of the disease in the patient upon diagnosis and admission.

The Institute was instructed by the Senate Appropriations Committee to begin such an effort in earnest. To date, there appears to be a literature search in progress, but, clearly, and according to the OTA's own report, the literature in question may be of dubious value. The Institute needs to redouble its efforts in this area, so that more individuals might receive appropriate care. In the absence of such research, the choice of level of care in alcoholism treatment becomes little more than a function of costs. We must guard against imposition of public policy when such policy is not based on research. This is particularly true in alcoholism treatment, as we need not return to the philosophy and policy which prevailed some 40 years ago, when alcoholics were deemed "incurable," and worthy only of the cheapest, custodial-type care--if, indeed, any care at all.

Impact of Treatment Assessment Research on Reimbursement

There is little disagreement that the inflation attendant to health care costs has vastly outdistanced nearly all other categories in the Consumer Price Index. As a result, we find ourselves entering an era of health care cost containment. In the alcoholism treatment field, we welcome this era, due to our firm belief that the treatment of alcoholism stands as

its own cost containing measure; this is, in fact, undeniable in comparison to the never-ending costs of treating the myriad consequences of untreated alcoholism.

Despite the fact that NIAAA is no longer directly involved in treatment, the Institute must maintain its reponsibility to disseminate accurate data on treatment effectiveness and cost-efficiency. Such data has a direct impact on private insurors. While insurance coverage--albeit to differing degrees--is available largely to inpatient, hosptial-based programs, it is scanty, indeed, for residential programs, and nearly non-existent for outpatient programs. This is clearly a contradiction in terms with regard to cost containment: The most intensive (and, often, the most expensive) level of alcoholism treatment enjoys better insurance coverage than less costly, less intensive approaches, which, sometimes, are more appropriate as well. Again, this is directly traceable to the lack of well-defined, methodologically sound treatment assessment research.

Members of the Subcommittee are no doubt aware that alcoholism treatment in distinct part units of general hospitals and in alcoholism specialty hospitals, is exempt from medicare's prospective payment system until October 1, 1985. This exemption was warranted because, due to inadvertent statistical flaws, the prospective payment for alcoholism treatment under medicare was originally based on an average length-of-stay of only 8.1 days. The Department of Health and Human Services granted a temporary exemption, rather than impose an unworkable, unreasonable and clearly inadequate DRG for alcoholism treatment.

As the lead agency on alcoholism research, it is crucial that NIAAA become involved in the effort to create an appropriate DRG structure for alcoholism treatment financed by medicare. Here, again, the absence of reliable data spawned a nearly disastrous result. NIAAA is in the best position to develop the type of data the Health Care Financing Administration requires to proceed. It is of greatest concern to NAATP that a contract has been let by the National Institute on Mental Health (NIMH) to develop DRG's for alcoholism (and psychiatric) treatment, with not so much as a mention of any role for NIAAA. How can the lead federal agency for research on alcoholism be left out of such an effort. Why, indeed, is development of an appropriate alcoholism DRG not the sole province of NIAAA? What assurances will the affected constituency have of input to such a project? NIAAA needs to exert the major role in this area, and NAATP suggests either

statutory or report language to ensure that role.

Involvement of the Private Treatment Field

The alcoholism field is fortunate to have, as the Director of NIAAA, Dr. Robert G. Niven. Dr. Niven has delivered bold, thoughtful leadership to the Institute and to the field in his comparatively brief stewardship. Dr. Niven comes to the Institute with a background in treatment as well as research, which, of course, is welcomed by the treatment field represented by NAATP.

There is a present need for greater involvement by the private treatment field in the policy-making of NIAAA. Clearly, as the provider of the bulk of alcoholism treatment in this county, the private sector has much to offer to the Institute. As the Institute moves toward greater effort in the treatment assessment area, NAATP believes avenues should be created to ensure formal as well as informal input to the Institute's decision-making process by the treatment field.

NIAAA's policies are guided, to a large degree, by its National Advisory Council on Alcohol Abuse and Alcoholism, a statutorily-mandated body, chaired by the NIAAA Director, and composed of representatives of the alcoholism field. NAATP notes, with regret, the conspicuous absence on the Advisory Council of a private treatment sector representative. NAATP believes that a slot on the Advisory Council must be statutorily reserved for such a representative, in order to facilitate necessary and official input on consideration of expenditures in the treatment assessment research area and other NIAAA policy and procedure areas. Just as it is imprudent to pronounce policy in the absence of research, it is inappropriate to generate treatment-oriented research in the absence of a representative of the affected field.

Broader NIAAA Policy-Making Authority Within Government

NAATP supports the need for greater policy-making authority for the Institute, as regards other agencies of the government. The need for this type of authority is clearly exemplified by the contradiction inherent in NIAAA's support of the notion of alcoholism treatment, compared to the Office of Personnel Management's (OPM) unilateral decision to eliminate Blue Cross/Blue Shield alcoholism coverage for 9.2 million federal employees, retirees and their dependents. On another front, the Health Care Financing Administration, a part of the same Department as NIAAA, proclaimed alcoholism

treatment to be an 8.1 day regimen, despite NIAAA's data supporting the state-of-the-art average length-of-stay of some 28 days.

It cannot be overstated that adequate research needs to be the basis of responsible public policy. As the lead federal research agency on alcoholism, NIAAA needs a concomitant role as the lead policy-maker within government. Without such a statutory mandation, other agencies, even in the same governmental department, will continue to operate in a vacuum. The Institute must be in a position to officially advise other governmental research, administrative and regulatory agencies, in order to better exercise and articulate a meaningful policy-making role.

Conclusions and Recommendations

Based on the preceding, the National Association of Alcoholism Treatment Programs recommends the following for the Subcommittee's consideration in the renewal of operating authority for the National Institute on Alcohol Abuse and Alcoholism:

1. Report language mandating a greater emphasis at NIAAA on treatment-related research, including such areas as patient placement, treatment outcome assessment and evaluation, cost-effectiveness and -efficiency, reimbursement policy, and comparative data and analysis on various levels of care.

2. Report language calling on the Institute to make the availability of funds for treatment assessment research known to the treatment field, so that field may be an active participant in such efforts.

3. Report language directing the Institute to disseminate its data and analyses on treatment assessment to the treatment field as soon as practicable after development.

4. Statutory language reserving one slot on the National Advisory Council on Alcohol Abuse and Alcoholism for a representative of the private alcoholism treatment sector.

5. Statutory or report language ensuring the involvement of NIAAA in the further development of an adequate DRG for alcoholism treatment under medicare.

6. Statutory language to ensure that NIAAA is seen as the lead agency within government on alcoholism policy, and

giving the Institute an official, government-wide policy advisory role on issues pertaining to alcoholism and its treatment.

In conclusion, NAATP wishes to express its very highest level of support for the continuation of the National Institute on Alcohol Abuse and Alcoholism and, indeed, for an expansion of its operating authority. The many contributions of the Institute in research, prevention and treatment of alcoholism have been crucial to our ability to better deal with this wide-spread disease.

Again, NAATP expresses its gratitude to the Subcommittee for this opportunity to make its views known. If our association can provide further information to the Subcommittee, we will gladly do so.

We respectfully request that this testimony be made a part of the permanent hearing record.

Thank you.

Senator HAWKINS. Thank you so much.

Dr. Blume, do you have a statement?

Dr. BLUME. First, let me thank you for the privilege of testifying today on behalf of the National Council on Alcoholism. And both on behalf of NCA and me personally, let me congratulate you on taking the chairmanship. We are just delighted to have you. I hope we will get better acquainted.

NCA, with its over 200 local level affiliate councils on alcoholism, is the oldest—we just turned 40 this year—and the largest association of volunteers in alcoholism. And though we certainly support public funds going into the alcoholism field, we ourselves do not accept public funds and are supported by private contributions.

My name is Sheila Blume. I am a psychiatrist. I am a member of the NCA board and its former medical director. I was also once in Tom's shoes as the State commissioner for New York for alcoholism, and am past president of the American Medical Society on Alcoholism and Other Drug Dependence.

The written testimony will give more fully what we have to say, but I would like to make a few points. First of all, NCA supports the mission of NIAAA and believes that significant and continuous increases in funding and the preservation of NIAAA's policy leadership role are absolutely vital to the development of any kind of aggressive national plan to combat alcohol problems. There, I second what you were saying.

Unfortunately, the authorization levels in the legislation before us, we feel, do not yet represent a sufficient response to the concerns raised by the research community, nor do they address the outcry of public alarm about the seriousness of alcohol problems. I think the public is beginning to grasp that now.

The authorization level of $47,835,000 represents a relatively slim increase over current funding, again with small increases in the two subsequent fiscal years that can only hope perhaps to

maintain current initiatives with relatively little promise for expansion.

I am afraid that these figures will serve to assure the continued placement of alcoholism research near the bottom of the Federal health care research expenditures, where it certainly does not deserve to be.

At the very least, we would respectfully request that you look closely at the funding levels proposed in the House of Representatives bill currently under consideration, which designates levels of $60 million, $69 million, and $80 million in its 3-year authorization figures, which more closely approximate the recommendations of the Institute of Medicine report that I know you are familiar with.

The second point: We are absolutely delighted to see a 3-year authorization proposed by this body. It is a time period which is sufficient to allow both continuity and reasonable oversight of the Institute's activity, and we applaud that.

NCA would further like to commend you for inclusion of a $10 million authorization for demonstration projects in alcohol abuse and alcoholism. Innovation is sorely needed and funds for that purpose are very welcome. They are hard to come by at the State level because the States are overwhelmed with treatment needs at the moment.

Finally, I would like to make some comments about women and alcohol and some of the needs for research in that area. NCA strongly supports the inclusion of the $1 million authorization in this legislation to report research initiatives on women and alcohol. We congratulate you and Senator Hatch for your leadership in this area.

I would like to make a few remarks about why we need this special attention. First, research emphasis on women and alcohol has been a very recent phenomenon. Alcoholism, as you said, has traditionally been perceived of as a male problem, and although one of the earliest autobiographies of an alcoholic to reach public attention was "I Will Cry Tomorrow," which was the story of a woman, such cases were thought of as rarities and they really did not impact on public consciousness.

Standard teaching about the physiology, the metabolism, and the psychology of alcohol, and standard teaching about alcoholism—for example, Jellinek's "Phases of Alcoholism"—are all based on research done on males.

This fact in itself would not be remarkable, except that when such studies have been repeated in women, the results are often very different.

The second point, then, is that women differ in their relationship to alcohol historically, sociologically, psychologically, and even in their physiological handling of alcohol as a drug.

For example, it was only recently discovered that at a standard dose of alcohol per body weight, women develop both higher peak blood alcohol than men and show more variability and less predictability in their response to alcohol. In addition, women taking oral contraceptives were found to metabolize alcohol more slowly. This is knowledge gained only within the past few years.

As an aside, so many of us promote the use of these cards: "Know your limit," "How many drinks lead to how much blood al-

cohol." But for women, the blood alcohol is higher than that card indicates because they respond in the way we have just discovered.

The disease of alcoholism also seems to differ in women who start their alcoholic drinking at a later age but progress more rapidly, show more depression, and suicide attempts, and, as you mentioned, have more problems with sedatives and tranquilizing drugs in addition to their alcohol abuse.

Some relevant research is summarized in appendix A. Women, because of their reproductive function, are also at special risk for the fetal-alcohol syndrome and other fetal-alcohol effects in their offspring, and these and other differences point to the urgent need for more knowledge in order to develop adequate approaches to prevention and treatment for women.

Also as an aside, I came here from another meeting in New York at which I got a copy of the warning poster that New York City has now mandated to be displayed wherever alcoholic beverages are sold. I think in spite of testimony to the contrary—I testified at that hearing, and our New York affiliate promoted this—I do not think it will put any alcoholic beverage supplier out of business. I think it is straightforward information and I would be glad to have you have it if you would like it.

Senator HAWKINS. Thank you very much.

Dr. BLUME. Third, the research on women and alcohol is still quite limited. It seems to be just plain easier to do research on male populations and it is not at all unusual, as in the famous Rand report of 1976 which analyzed the treatment outcome in thousands of patients who were treated in NIAAA-funded programs, to simply throw out the female data because it was so different from the male and because the numbers were smaller.

The current studies on genetic predisposition to alcoholism in children of alcoholic parents are being done almost entirely with males. Because of all these factors, the National Council on Alcoholism has encouraged special attention to the needs of women in alcohol research, as well as in programming.

To conclude, the legislative directive calling for the Secretary of Health and Human Services to develop a comprehensive plan to combat alcoholism and alcohol abuse illustrates Congress' continuing conviction that strong Federal leadership is necessary for an adequate response to these public health problems.

For this, we are truly grateful. The formulation of such a plan is long overdue and will furnish the executive branch, the Congress, the alcoholism field, and interested citizens with valuable guidance in addressing the very wide range of alcohol problems. Thank you.

[The prepared statement of Dr. Blume with attachments follow:]

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40th Anniversary
1944 - 1984

STATEMENT OF

DR. SHEILA BLUME

on behalf of the

NATIONAL COUNCIL ON ALCOHOLISM, INC.

before the

Subcommittee on Alcoholism and Drug Abuse

U.S. Senate

On reauthorization of the National Institute on Alcohol Abuse and Alcoholism

May 1, 1984

NCA, the only national voluntary health organization dedicated to combatting the disease of alcoholism, is supported entirely by private contributions and accepts no government funds.

On behalf of the National Council on Alcoholism I would like to thank you, Senator Hawkins, for the opportunity to express our views on the reauthorization of the federal alcoholism effort. I would also like to congratulate you on your assumption of the Chair of the Subcommittee on Alcoholism and Drug Abuse. We look forward to working closely and cooperatively with you and your staff during your tenure as Chair.

My name is Sheila Blume, and I am a Board member of NCA and past Medical Director. I am a psychiatrist who has specialized in alcoholism for the past 22 years. I also am a past President of the American Medical Society on Alcoholism, and I served as Director of the New York State Division of Alcoholism and Alcohol Abuse.

NCA, with more than 200 affiliates in communities across the nation, is the oldest and largest association of volunteers in the field of alcoholism -- dedicated to eradicating the stigma surrounding the disease of alcoholism, making treatment accessible, and promoting activities to reduce the social and economic toll wreaked by alcoholism and alcohol-related problems. In this connection, we are firmly committed to the proposition that the problem of alcoholism and alcohol abuse is of such sweeping dimensions that it constitutes a major public health threat and as such demands the application of public funds for research, prevention and treatment. However, NCA itself does not accept government funds, relying solely on contributions from the private sector.

Since its inception with the mandate of the Hughes Act, NIAAA has acted as a focal point and policy voice for federal efforts to understand alcoholism and alcohol abuse and its impact on individuals and families. NIAAA is the primary funding resource of research initiatives to determine the causes of this deadly illness, to evaluate modalities of treatment for effectiveness in addressing the needs of various populations, and to pursue avenues of investigation which may

contribute to a comprehensive approach for prevention of alcoholism and other alcohol-related problems.

NCA has acted as a long-time supporter of NIAAA. We believe that the policy objectives of NCA -- reducing stigma and making treatment accessible for alcoholics and their families, as well as promoting activities to combat alcoholism and alcohol abuse -- have been dramatically advanced by the presence and growth of NIAAA. Just recently, a collective meeting of alcoholism professionals, physicians, attorneys, and government officials held under the auspices of the American Assembly of Columbia University recognized the critical role of NIAAA in forging a comprehensive and effective policy to combat alcoholism and other alcohol-related problems. That distinguished body, of which I was a part, further acknowledged that the successes of prevention and treatment initiatives are inextricably related to the strength and effectiveness of the research on which the efforts are based. In this regard the final recommendations of the Assembly call for a doubling of the NIAAA research budget as soon as possible with steady increases available thereafter.

The landmark 1980 Institute of Medicine report took note of numerous opportunities in the alcoholism field that await investigation and the good number of research proposals of high quality which cannot be funded because of budgetary restraints. The panel highlighted research on consumption of alcoholic beverages and risk factors for alcohol abuse as two major areas of research opportunity. Futhermore, the 1983 report of the NIAAA Research Planning Panel, on which I served, underscored the findings of the Institute of Medicine study by reiterating a concern for the low funding level for alcohol-related research and calling for a sustained increase in funding over many years to meet the needs of the field.

Exciting breakthroughs in the last half decade firmly establishing the existence of a genetic predisposition to alcoholism were cited by the Research

Planning Panel as promising research avenues in need of expanding federal support. It also highlighted deficiencies in NIAAA's research training program resulting from inadequate funding levels, with a particular impact on such relatively new alcohol research disciplines as prevention. The research community at large, particularly those individuals traditionally underrepresented including women and minorities, need to know that there is stability and growth in this field to make alcohol-related research a viable career goal.

Regrettably, the authorization levels in the legislation before us do not represent an adequate response to the concerns raised by the scientific and research community, nor do they address the outcry of public alarm about the pervasiveness and destructive impact of alcoholism and alcohol abuse on families, communities, and the very productivity of the nation at large. The authorization level of $47,835,000 represents a slim $5 million increase over current funding with small increases in the two subsequent fiscal years that can only hope perhaps to maintain current initiatives with little promise for expansion. These figures will serve to assure the continued placement of alcoholism research near the bottom of federal health care research expenditures despite the existence of a public consensus that it is a major public health problem in the nation today and a view held by many -- that it is indeed the major public health problem. We urge you to reconsider these low authorization levels and suggest to you that federal support for alcoholism research should be authorized and appropriated at levels which bear a closer relationship to the economic and human costs incurred by the American people by this illness -- a cost estimated by the Office of Technology Assessment to approach some $120 billion a year. At the very least, we would respectfully request that you look closely at the funding levels proposed in the House of Representatives bill presently under consideration which designates levels of $60 million, $69 million and $80 million in its three year authorization -- figures which closely approximate the recommendations of the

Institute of Medicine report. We are delighted to see a three year authorization proposed by this body -- a time period that is sufficient to allow for both continuity and reasonable oversight of the Institute's activities. We would hope, however, that this authorization period would not serve to stifle exciting progress in alcoholism research well under way by eliminating any possibility for substantial enhancement of these efforts over the next three years.

NCA recognizes an urgent need for high quality research directed at the special relationship of women to alcohol abuse and alcoholism. In this regard, we strongly support the inclusion of the $1 million authorization in this legislation to support research initiatives on women and alcohol. We congratulate you and Senator Hatch for your leadership in this area.

I would like to make a few remarks about the special problems of alcohol in relation to women, and about needs for research in this area. There are a few points to stress. First, research emphasis on women and alcohol has been a very recent phenomenon. Alcoholism has traditionally been perceived as a male problem, and although one of the earliest autobiographical works to reach public attention, "I'll Cry Tomorrow," was written by a women, such cases were thought of as rarities. Standard teaching about the physiology, metabolism and psychological effects of alcohol, and standard teaching about alcoholism, for example, Jellinek's Phases of Alcoholism, are all based on research done on males. This fact in itself would not be remarkable, except that when such studies have been repeated in women, the results are very different.

The second point then is that women differ in their relationship to alcohol, historically, sociologically, psychologically, and even in their physiological, handling of alcohol as a drug. For example, it was only recently discovered that at a standard dose of alcohol per pound of body weight, women develop both higher peak blood alcohol levels and more variable, less predictable responses. In addition, women taking oral contraceptives were found to metabolize alcohol more

slowly. The disease of alcoholism also seems to differ in women who start alcoholic drinking at a later age, but progress more rapidly, show more depression and suicide attempts, and have more problems with sedative and tranquilizing drugs. Some of the relevant research is summarized in Appendix A of this testimony. Women, because of their reproductive function, are also a special risk group for the Fetal Alcohol Syndrome and other fetal alcohol effects in their offspring. These and other differences point to an urgent need for more knowledge in order to develop adequate approaches to prevention and treatment for women.

Thirdly, research on women is still quite limited. It is just plain easier to do research on male populations and it is not at all unusual, as in the famous Rand Report of 1976 which analyzed treatment outcome in thousands of patients treated in NIAAA funded programs, to simply throw out the female data because it was so different from the male and because the numbers were smaller. The current studies on genetic predisposition to alcoholism in children of alcoholic parents are being done almost entirely with males. Because of the above, the National Council on Alcoholism has encouraged special attention to the needs of women in alcohol research and in programming.

NCA further commends the Chair for the inclusion of a $10 million authorization for demonstration projects in alcohol abuse and alcoholism. The creation of the ADMS Block Grant has rendered the States the primary source of funding for alcoholism treatment. The enormous task of administering an adequate and quality service delivery system has left the States with few if any additional resources to improve upon or experiment with innovative and challenging new programs in the prevention and treatment areas. Federal support for demonstration projects is not only, in our view, an appropriate federal role, but also an integral component for the building of a strong federal-state partnership and can represent a key form of technical assistance rendered to the States. We hope you will join us

in vigorously encouraging full appropriations for this demonstration authority.

The legislative directive calling for the Secretary of Health and Human Services to develop a comprehensive plan to combat alcoholism and alcohol abuse illustrates the continuing conviction of Congress that strong federal leadership is necessary for an adequate response to these public health problems. For this, we are grateful. The formulation of such a plan is long overdue and will furnish the Executive Branch, the Congress, the alcoholism field and interested citizens with valuable guidance in addressing a wide range of alcohol-related problems.

NCA has also been concerned that alcoholism as a disease necessitating intervention, treatment and rehabilitation has not always received appropriate attention during formulation of public policy on drunk driving and other alcohol-related problems. Furthermore, we are somewhat disheartened that despite growing evidence that alcohol is a major factor in the morbidity and mortality of the American people -- and consequently a primary force behind escalating health care costs, attention to alcoholism and alcohol-related problems remains a relatively low priority on the nation's health agenda. Despite recent significant increases in NIAAA's research authorization, for which we are grateful, alcoholism research continues to be grossly underfunded in relation to the national burden of the illness and relative to other health conditions of its magnitude. The last three years have seen a dramatic retrenchment in federal support for alcoholism treatment, the elimination of NIAAA's clinical training budget, the demise of the National Commission on Alcoholism and Alcohol-Related Problems, the retraction of the short-lived alcoholism and drug abuse benefit in federal employee's health insurance plans and a virtual halt to substantive NIAAA and NIDA initiatives to target underserved populations in need of prevention and treatment services. Moreover, the recent national chorus of concern over social problems to which alcoholism is a major contributor such as domestic violence and the plight of the indigent homeless has been all but silent about the alcoholic. Such silence is

disturbing since studies conducted by NIAAA and other public and private agencies indicate that the alcoholic is a frequent perpetrator and victim of family violence. And ironically, 14 years after the initiation of the federal alcoholism effort, which had its genesis in long overdue public attention to the plight of the public inebriate, public attention and money to respond to the needs of the homeless have virtually ignored the significant number of that population who are alcoholic.

Now in our 40th year, NCA remains an outspoken advocate for the needs of the suffering alcoholic. But we cannot do the job alone. Nothing short of aggressive federal leadership is necessary to ameliorate the problems of alcoholism and alcohol abuse in the nation. The federal mission to combat alcoholism and alcohol abuse has its heart and soul in NIAAA. The Institute must continue to grow if it is to remain viable as a reservoir of national research, the focal point for federal policy on alcohol problems, and a resource accessible to all Americans who seek information about this deadly, but treatable disease.

CHAPTER 13

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Psychiatric Problems of Alcoholic Women

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Women and Alcohol

Strong feeling, and particularly strong disapproval of drinking by women has been part of the Western culture for centuries. In the early days of ancient Rome the drinking of alcohol by women was strictly prohibited.[1] A law of Romulus provided the death penalty for women who drank as well as for those who committed adultery. There are records of women having been put to death for the offense of having drunk wine or having been caught with the keys to the family wine cellar. The idea that drinking by women was abhorrent in itself and would lead to lascivious behavior was already established in the ancient world.

In 1798, Immanuel Kant expressed an opinion about the sobriety of both Jews and women. He stated that both groups do not get drunk and avoid all appearance of drunkenness because their position in the community rests upon the belief of other in their piety and chastity:

> All separatists, that is, those who subject themselves not only to the general laws of the country but also to a special sectarian law, are exposed through their eccentricity and alleged chosenness to the attention and criticism of the community, and thus cannot relax in their self-control, for intoxication, which deprives one of the cautiousness, would be a scandal for them.[2]

Jews and women have been compared in one other respect related to drinking problems. Since both groups are thought to have a relatively low incidence of alcoholism, it is argued that any individual alcoholic from either group must be more deviant from the norm than would be true for a member of

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a group with a higher incidence of alcoholism. Therefore, Jewish and female alcoholics should show more underlying psychopathology. This "sicker" hypothesis has been questioned for both Jews and women.[3,4] The belief, however, persists, and adds to the special problems of stigma faced by women who drink to excess. This stigma and the double standard of drinking in Western society have been discussed by several authors.[5,6]

In spite of the strong feelings of our society toward women and alcohol, relatively little research into the physiological, psychological, and sociological aspects of women's drinking was performed prior to the mid-1970s, when a nation-wide movement encouraged by the National Council on Alcoholism and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) focused attention on this problem. Nearly all of the classical studies done on the physiology, biochemistry, and metabolism of alcohol had been done in males. The initial studies on the nature and course of the disease alcoholism were also done in men, for example, Jellinek's classic study of the course of the illness in 1,000 members of Alcoholics Anonymous.[7] A recent NIAAA-sponsored research review[8] calls attention both to recent findings and unanswered research questions concerning alcohol problems in women. Recommendations of the NIAAA research group range from a proposal to specify the sex of subjects in the titles of project reports to programs to increase the participation of qualified women scientists and administrators in alcoholism research.

Recent interest in the effects of maternal drinking on the fetus in producing both the fetal alcohol syndrome (FAS) and other alcohol-related birth defects has further increased the level of public and professional interest in the use of alcohol by women.[9] Fetal alcohol syndrome is thought to be the third most common cause of mental retardation associated with birth defect in the United States. Of these three (Down's syndrome, spina bifida, and fetal alcohol syndrome), only FAS is preventable. Effective prevention of FAS must include both identification and treatment of the pregnant alcoholic woman.

The Alcoholic Woman

Recent reviews of literature present a description of the clinical characteristics of the alcoholic woman, as she is found in the community and as she presents for treatment.[10–13]

Clinical Characteristics

Diagnosis. There has been considerable dispute about the use of the terms "alcoholic," "problem drinker," "alcohol abuser," and so forth. The term "alcohol dependence syndrome," as defined by the World Health

Organization in its *International Classification of Diseases—9*[14] and the American Psychiatric Association in its *Diagnostic and Statistical Manual of Mental Disorders* (Third Edition),[15] can be applied to male and female alike. However, other definitions and diagnostic standards are based on average levels of alcohol intake which are thought to be "hazardous." These have usually used the same cut-off point for male and female drinkers in spite of the fact that both women social drinkers and female alcoholics presenting for treatment drink considerably less than men. For example, as reported in the so-called Rand Report, non-problem-drinking women averaged 0.44 ounces of absolute alcohol daily compared to the male average of 0.91. Women accepted for treatment in the NIAAA-sponsored alcoholism programs surveyed in the report averaged 4.5 ounces of absolute alcohol per day compared to the male average of 8.2 ounces.[16] These differences are related, at least in part, to differences in body weight and proportion of body water. Thus, any definition of a population at risk for alcohol problems based on quantity of drinking must have separate standards for males and females. Screening tests aimed to identify problem drinkers have also tended to be developed with male populations. It is important that they be validated for women before they are used for this purpose.

Family History. There is a high incidence of both alcoholism and depression in the close relatives of alcoholic women.[18] The studies of Goodwin *et al* on adopted-out children of alcoholic biological parents in Denmark present strong evidence for the existence of a genetic predisposition to alcoholism in males.[19] The women in Goodwin's study, however, did not show this trend as clearly as the men.[20] This result is partly a product of the low incidence of alcoholism among women in Denmark, which led to a small number of cases in the study. However, it also may reflect, in part, the greater relative importance of developmental and psychosocial factors in women's alcoholism.

Psychology and Behavior. Most psychological and social theories of the causation of alcoholism do not distinguish between the sexes. The few longitudinal studies that shed light on social and psychological factors which predispose to alcoholism show markedly different results for males and females. The Oakland Growth Study,[21] although it had few female problem drinkers, identified general feelings of low self-esteem and inability to cope in girls who later became problem drinkers when they were tested at the junior-high-school and high-school levels. This was not true of the males.[22] In a 28-year follow-up of a study of drinking among American college students, researchers found that factors predictive of problem drinking in later life differed considerably between males and females.[23] Analysis of the data made it necessary to construct different definitions of "alcohol involvement" at the college level and of "problem drinking" at follow-up for males and females. The best predictor of later problems for college women was a high score on the

"feeling adjustment" scale, composed of such items as drinking to relieve shyness, drinking to get high, drinking to be gay, and drinking to get along better on dates. Among men, those with "incipient problems" in college were more likely to show up in the problem drinker group at follow-up. In neither sex was the presence of overt alcohol problems in college the best predictor of problem drinking 27 years later.

One psychological theory that has focused specifically on the alcoholic woman has been that of sex role conflict. The theory is based on socially accepted definitions of masculine and feminine behavior. It postulates that women who develop alcoholism have strong identification with feminine roles at the conscious level but strong unconscious masculinity. This disparity creates a conflict at least partially relieved by the ingestion of alcohol, which enhances feelings of femininity in both normal and alcoholic women.[24] The concept of sex role conflict has been further developed to include women with conflict between conscious masculine strivings and unconscious feminine identification.[25] A recent study from the University of California investigated conscious and unconscious masculinity and femininity in 120 female alcoholics, 119 nonalcoholic women, and 118 women in treatment for psychiatric and emotional problems.[26] The study concluded that although a sex role conflict between "unconscious masculinity" and "conscious femininity" was more prevalent among alcoholic women than among the normal controls, less than one quarter of the total alcoholic sample showed this pattern of conflict. When sex role conflict was defined to include both conscious femininity and unconscious masculinity and the reverse, there was no significant difference between the incidence of sex role conflict in the alcoholic women and the normal controls. Sixty-six percent of the alcoholic women, 72% of the treatment controls, and 71% of the normal controls scored feminine on both conscious and unconscious measures. Those alcoholic women who manifested sex role conflict differed from the remainder of alcohlic women in showing lower self-esteem and a higher incidence of having had an absent parent during childhood. Certainly identification of alcoholic women suffering from such conflict is an important consideration for psychiatric treatment.

Physiology. Recent studies have shown differences between the effects of single doses of alcohol in normal men and women. Given a standard dose of alcohol based on body weight, women showed both higher and more variable peak blook alcohol levels, with higher peaks obtained during the premenstrual phase.[27] Women taking exogenous hormones, for example, birth control pills or estrogen replacement, tended to metabolize alcohol more slowly. Such differences will have an influence both on the amount of alcohol consumed by women and the relative predictability of the effect of a given number of drinks. There is some evidence that women spontaneously drink less during pregnancy, when hormone levels are high.[28]

Course and Symptoms. Most researchers agree that women coming to treatment for alcoholism differ from their male counterparts in a number of

ways. Women start drinking and begin their pattern of alcohol abuse at later ages but appear for treatment at about the same age as male alcoholics. This points to a more rapid development or "telescoping" of the course of the illness in women. Alcoholic women are more likely to be divorced when they enter treatment or to be married to or living with an alcoholic "significant other." They are more likely than the alcoholic man to date on the onset of pathological drinking to a particularly stressful event. Women are more likely to have histories of both suicide attempts and previous psychiatric treatment. Their motivations to enter treatment and the problems they perceive relating to alcohol are more likely to be health and family problems, whereas for the male, job problems and trouble with the law, particularly arrests for driving while intoxicated, are more prevalent. Women alcoholics have a high incidence of obstetric and gynecological difficulties and may be more likely to develop cirrhosis than the male. Various studies have shown that women more often present with histories of other substance abuse along with their alcoholism, particularly tranquillizers, sedatives, and amphetamines.[29] Female alcoholics are also more likely to report such symptoms of psychological distress as anxiety and depression, and have a lower self-esteem than their male counterparts.[30]

Subtypes of Alcoholism. There have been many attempts to develop systems for subtyping of patients suffering from alcoholism. The most useful of these subtypings, particularly in women, is the distinction between primary and secondary alcoholism. Secondary alcoholism is defined as alcoholism associated with either preexisting diagnosable psychopathological states, or with such states developing during a prolonged period of abstinence. Primary alcoholism arises without such a history.[31] When categorized in this way, most alcoholic patients appearing for treatment are of the primary type. Among men the most common secondary alcoholism is that associated with sociopathy. In women the most common type is "affective alcoholism," usually associated with unipolar depression. This latter pattern may be seen in one fifth to one quarter of a typical female treatment population. Diagnosis must be based on a careful life history, since the presence of depressive symptoms at the time of treatment will not differentiate between the two groups. Once a woman is diagnosed as a secondary alcoholic suffering from affective alcoholism, an appropriate long-term treatment plan would include continuing contact during sobriety with attention to possible recurrence of depression. Early treatment of such recurrent can help the patient maintain her sobriety and well-being.

Fetal Alcohol Syndrome

Women alcoholics in the childbearing years should be screened for pregnancy, and those with children born during heavy drinking periods should have these children screened for fetal alcohol syndrome and other

related birth defects. Both animal and human research leads to the expectation that children of heavily drinking mothers are more likely to be growth-retarded, hyperactive, and slower to develop. Those with the full fetal alcohol syndrome present a combination of birth defects including both prenatal and postnatal growth retardation (small for gestational age with failure to "catch up" in spite of good postnatal nutrition), small head circumference, mild to moderate mental retardation, small eyes, often with strabismus and/or ptosis, hypoplasia of the maxilla, a long upper lip with a flattened philtrum and thinned vermillion, and a small upturned nose. In addition, there may be skeletal, joint, genital, renal, skin, and cardiac defects.[9,32] Although the full fetal alcohol syndrome has only been seen to date in women whose alcohol intake averaged six drinks or more per day throughout pregnancy, safe levels of alcohol intake both in terms of timing during pregnancy and pattern of drinking are as yet unknown. There is evidence, however, that interruption of excessive drinking during pregnancy leads to lower incidence of birth defects.[33]

The Alcoholic Woman as a Woman

Before considering the treatment of alcoholic women, it is important to note that they share many of the problems common to all women in contemporary society.[34,35] The recognition of these factors and their incorporation into a program of rehabilitation for the alcoholic woman will often make the difference between success and failure of treatment.

An important factor in the psychiatric treatment of women is both public and professional perceptions of mental health and of appropriate masculine and feminine sex roles.[36] A particularly enlightening study published in 1970[37] explored sex role stereotypes in 79 clinically trained psychologists, psychiatrists, and social workers. It was found that definitions of a healthy, mature, and socially competent adult matched those for a healthy, mature, and socially competent male, while traits thought to be characteristic of healthy women were perceived as significantly less healthy for an adult of unspecified sex. Such stereotypes are important underpinnings of theories of sex role conflict. They also are central to notions of mental health based on successful adjustment to social expectations. A competing concept of masculine and feminine traits in mental health is the concept of androgyny. Androgyny stresses a balance or mixture of traits considered stereotypically "masculine" of "feminine" by society, used in a flexible way. The University of California study quoted above[26] attempted to assess androgyny in the three study groups of women: women in treatment for alcoholism, women in treatment for other emotional disorder, and normal nonalcoholic women. The alcoholic women were significantly less androgynous than the normal controls but did not differ in this respect from the treatment controls. Androgynous rather than

stereotype feminine behavior would seem a most appropriate treatment goal for the alcoholic women.

Since women alcoholics have difficulties with self-esteem, it is important to consider aspects of female identity. A common component of identity for both men and women is occupation: I am what I do. It is thus important to note that in contemporary American society "women's work" is afforded much lower status than work usually associated with the male. Although increasing numbers of women are part of the work force, they are concentrated in low prestige jobs and earn an average of only slightly more than half the average income for men.[38] Work performed in the home is assigned essentially no social or economic value. (Does your wife work? No, she is a housewife.) The vast majority of working women who are also married continue to carry the responsibility for all or almost all of the cleaning, laundry, cooking, shopping, and child care.[39] Women are often underpaid, underemployed, undervalued, and overstressed. Striving for perfection in these competing areas of life will produce problems in any woman. In a recovering alcoholic woman attempting to allay feelings of guilt and shame and to make up for lost time, the problems will be even more intense.

A role usually assigned to the woman in contemporary society is that of keeper of the family. In separation or divorce, a wife continues to be awarded custody of minor children in most cases, even when the separation is based in part on her problems with alcohol. Many alcoholic women presenting for treatment are heads of single parent families, struggling to provide financial support as well as household and child care. It has been noted previously that alcoholic women are often married to men who are also problem drinkers. Because of her role as keeper of the family, the wife of an alcoholic husband often feels guilty and responsible for her husband's drinking. If she does not have available to her an effective network of social and emotional support outside the home, such as an understanding family or membership in Al-Anon Family Groups, she may begin to use alcohol as a temporary solution to her marital distress and begin a pattern of alcoholism in herself. Thus, in the treatment of both married alcoholic men and women, the spouse should be considered at risk for alcohol problems. A careful drinking history should be taken, and preventive measures instituted in the form of family treatment wherever possible. Particularly in order to reach those women who are heads of single parent families, but also for all who have young children, arrangements for child care and other household assistance will often by critical. It is difficult or impossible for a women to concentrate on therapy when her children are unsupervised at home.

A third aspect of a woman's identity is that she often, in contrast to a man, derives her identity through her relationship to others. She takes her husband's name at the time of marriage and is often known as "Sam's wife" or "Pat's mother." Even after the relationship is ended, she may be identified as

"Joe's widow" or "Sid's ex-wife." Part of the rebuilding of self-esteem requires attention to the alcoholic women's feelings about herself as an individual.

A fourth component in women's identity is tied to sexuality. Much has been said about woman as sex object, and the association in the public mind between alcohol abuse and promiscuity has been part of Western culture for centuries. Although much study has been given to the effects of alcohol on sex hormones and sexual performance in the male, practically nothing is known about these factors in the female. One researcher recently reviewing the field wrote, "Most experts comment on human sexual behavior and alcohol as though only males drink and have sexual interests."[40] Clinicians have recognized a high incidence of obstetric and gynecological problems in populations of female alcoholics in treatment.[11,12] Alcoholic women often complain of anorgasmia and lack of sexual interest. Some have, in fact, engaged in sexual behavior of which they would not ordinarily approve, either in an attempt to find a solution to their sexual problem, or searching for an escape from loneliness, primarily while intoxicated. However, the majority of alcoholic women are solitary drinkers who do their drinking at home. Even women on skid row are more likely to be solitary drinkers than men. Thus, only a minority of alcoholic women are regularly exposed to men while drinking, and fewer fit the cultural stereotype of promiscuity. Homosexual women are said to have an unusually high incidence of alcohol problems.[17] Those women whose problems with identity center around their sexuality will need special consideration of this factor during treatment.

Lastly, a woman's identity is shaped by her socioeconomic status and the subcultural group to which she belongs. Cultural differences in attitudes and female roles may serve as a help or hindrance in casefinding and treatment, which should be tailored as much as possible to the ethnic background of the patient. It is of little value, for instance, to expect a woman to go out alone to evening Alcoholics Anonymous (AA) meetings at which both sexes are present, when her subculture proscribes such an activity. On the other hand, the therapist may take positive advantage of extended family systems by involving them in welding a support system for the newly-sober patient.

Psychiatric Problems

Mention has been made of the high incidence of reported anxiety, depression, and other symptoms of psychological distress in women alcholics coming to treatment. It has also been pointed out that women more often than men are able to pinpoint a specific stressful time in life when their abuse of alcohol began. These reports should not be looked upon as rationalizations, but as clues to the drinking patterns, alcohol dependencies, and treatment strategies that are best suited to each alcoholic woman. Although some secondary alcoholics will be suffering from schizophrenia, neurosis, and other

psychiatric disorders, specific studies of the incidence of these combined disabilities in women have been few. Winokur and Clayton[18] were able to delineate specific sub groups of female alcoholics in part based upon psychiatric diagnosis.

Halikas *et al*[41] recently reported on 71 alcoholic women who were interviewed in a systematic structured psychiatric interview. Among these patients, 56% fulfilled criteria for some psychiatric diagnosis other than alcoholism.

The most common psychiatric diagnosis, in addition to alcoholism, was affective disorder. Twenty-eight percent of the total population fulfilled criteria for a diagnosis of either unipolar (24%) of bipolar (4%) affective disorder. Another 10% had a mixture of additional neurotic symptoms including anxiety, phobias, obsessions, and compulsions. A third group of 6% of the total population had manifest psychotic symptoms at some point in the past in addition to their alcohlism and affective disorder.

Nineteen percent of the total population fulfilled criteria for the diagnosis of antisocial personality. In the diagnosis of alcoholism and antisocial personality, 8% also had a variety of other psychiatric symptoms such as anxiety, depressive complaints, and obsessive-compulsive symptoms. It also has been assumed that the acute and chronic brain syndromes associated with alcohol withdrawal and prolonged alcohol use do not differ between men and women, although this is another area which awaits study.[42]

Treatment of Alcoholic Women

Casefinding. The three most effective early intervention programs available today, drinking-driver rehabilitation, public intoxicant intervention, and employee assistance programs, have one characteristic in common: they reach a far greater proportion of male problem drinkers than female ones.[17] Since the problems that motivate women to go into treatment are most likley to be health and family problems, and primary casefinders for the female will be physicians, other health professionals, social and family service agencies, and attorneys. These professionals require special training to enhance their abilities to identify and intervene effectively in women's alcohol problems. Because of the potential to prevent fetal alcohol syndrome, special attention must be given to women of childbearing age. The added motivation provided by the wish to bear a healthy child can be most helpful in treating the pregnant alcoholic. Wives of alcoholic husbands and mothers of children being evaluated or treated for mental retardation and/or behavioral and emotional problems should be considered target groups for casefinding.

Detoxification. In detoxifying the woman alcoholic, either on an inpatient or outpatient basis, special care must be given to the taking of a complete history of psychotropic drug use. Since women are more likely to be

users as well as abusers of such substances, the clinician should be alert to the delayed symptoms that are associated with withdrawal from the benzodiazepines. These symptoms are likely to begin between two and ten days after the abrupt discontinuation of alcohol and drug use and may include seizures as well as insomnia, tremor, anorexia, hallucinations, and disorientation.[43] Delayed convulsions in any alcohol withdrawal should lead the clinician to suspect drug dependence in the differential diagnosis along with head trauma and other causes for seizures.

Psychotherapy. Review of individual psychotherapy, the constructive use of typical alcoholic defenses, and the techniques of group therapy, family therapy, and psychodrama are available in this volume and elsewhere.[44] A few points specific to the treatment of women will be made in this section. Opinions differ regarding the relative efficacy of individual versus group therapy for alcoholic women, and of mixed-sex versus all-female groups.[17] In the absence of comparative studies, the best that can be said at present is that all three modes of therapy can be successful, provided that the therapist is sensitive to the special needs and problems of women.

Early in treatment, by whatever modality, emphasis is placed on two main factors. The first is the education of the patient and family in the disease concept of alcoholism and the necessity for a long-term treatment program for all involved. In dealing with an alcoholic women, there should be particular emphasis on the effects of drinking during pregnancy and the dangers of abuse of psychoactive drugs. Her children should be evaluated and helped in whatever way possible. Al-Anon and Alateen are widely available self-help groups which provide invaluable assistance to the families of such patients. The second emphasis early in treatment is on practical techniques for attaining abstinence. Contact with other alcoholic women who have recovered from the illness is of tremendous help in this endeavor. Such contact may be made in Alcoholics Anonymous or Women for Sobriety,[45] where such groups are available. A number of autobiographical works by recovering alcoholic women may also be helpful.[45–47] Key objectives during this phase are instilling hope and allaying guilt, a special problem with the alcoholic woman who faces a particularly strong societal stigma and often enters treatment with marked depression and reduced self-esteem. Teaching the techniques of deep relaxation and other nondrug measures for anxiety relief may also be very helpful at this stage.

With the relief of initial anxiety and depression, a great deal of buried anger may surface. The patient must be helped to evaluate this anger in terms of her own psychological, interpersonal, and social reality, bearing in mind the special problems in women outlined above. Channeling this anger and other energies and helping the patient structure time previously taken up by activities centered around drinking will be major issues in the second phase of treatment.

The use of psychoactive drugs should be kept to a minimum because of the danger of drug dependence. Many women recover from the depressive symptoms present during and immediately after detoxification without antidepressant drugs, in response to psychotherapy and group support as sobriety becomes established. In some cases, such drugs play an important role, as they may in the treatment of recurrent depression in the affective alcoholic woman. Disulfiram (Antabuse) may be helpful in the early stages of treatment of the nonpregnant women, although many patients prefer to try to maintain abstinence without it. In these patients, disulfiram is particularly helpful in treatment after relapse, when the patient may be amenable to this additional motivational aid.

Once abstinence has been established, psychotherapeutic attention will focus on remaining problems in the alcoholic patient's life. Each case must be handled differently, since no generalizations will apply to all women in this phase of treatment. Some, as we have mentioned above, will be suffering from affective alcoholism and will require prolonged contact with attention to possible recurrence of depression. Some will have predominantly sexual problems, either relating to sex role confict, to sexuality, or to specific marital problems. Assistance with parenting problems, assertiveness training, family therapy, vocational rehabilitation, and legal or spiritual counselling may be of considerable help in any individual case. Once sobriety is well established and new and constructive ways of handling the old problems previously dealt with by the use of alcohol have been developed, many women will have completed the formal part of their treatment. All should be encouraged to participate in long-term follow-up self-help groups, such as Alcoholics Anonymous or Women for Sobriety, and further professional help should be made available at times of particular stress. No patient should feel that he or she will receive help only if there is a return to active drinking. Some women, having attained a stable sobriety, will elect to continue psychotherapy in order to understand and alter residual neurotic or character defenses.

Among the pitfalls in psychiatric treatment of alcoholic women is the establishment by the patient of a hostile-dependent relationship on the therapist. The therapist must walk a thin line which includes a clear expression of the therapist's approval and expectation of sobriety, and at the same time makes clear that the responsibility for that sobriety is squarely in the lap of the patient. The patient may test the therapist's concern by a return to drinking. If she appears for an individual or group session under the influence of alcohol, care must be taken that neither overt nor subtle rewards for this behavior are provided. Such rewards might include being oversolicitous or allowing the patient to monopolize a group session. The therapist should clearly state the expectations that the patient will appear for the next session sober. The therapist must make sure realistic plans have been made to achieve that goal. Patients who miss a session should be pursued aggressively. Such a patient

who, when contacted, states, that she feels she no longer needs help is likely to be heading for a relapse, whether or not she is consciously aware of that fact. Treatment should be terminated only after mutual discussion which includes plans for participation in a long-term self-help group. Particular attention must also be given to strict respect for patient confidentiality. Because the societal burdens of guilt and shame lie strongest on the alcoholic woman, she must be assured that statements made in group or individual treatment will not be repeated to others. The federal regulations for confidentiality of alcohol and drug abuse records go far to protect such information.[48]

Prognosis

Recent reviews of the literature[4,17] report that for unselected groups of alcoholic patients the prognosis in males and females is roughly the same. One study[49] followed a group of 103 alcoholic women ten years after treatment in a public and private mental hospital in St Louis. Control groups included 69 women treated for affective illness and 103 normal sisters of the probands. At ten years the differences in morality were striking. Thirty percent of the alcoholic group was dead, although their average age at treatment was only the mid-forties. The average age at death was 51 1/2 years, with 82% of the deceased alcoholic women dying under the age of 60 and half of these deaths associated with violence, suicide, or cirrhosis of the liver. In contrast, 16 1/2% of the depressed women had died, at an average age or 71 1/2 years. Only 10% of the depressed women died under the age of 60, and only 20% had causes of death that might have been connected with the depressive diagnosis.

This highly mortality rate points up the importance of making treatment available to all women in need. Treatment of relapses should be as vigorous as the initial episode. A positive attitude communicating an expectation of success on the part of the therapist is an important ingredient in such treatment.

Conclusion

This chapter has presented an overview of alcoholism in women with special attention to psychiatric problems and issues in treatment. We still have much to learn about alcohol problems, their causes, natural histories and outcomes, and the intervention and treatment approaches that work best with each problem type and subtype. Although this is true for all alcohol problems, it is especially true for women's problems, about which our knowledge is even less secure. Statistical estimates of numbers of female problem drinkers in the United States were purposefully omitted from the chapter. Such estimates

vary widely depending on populations studied. Male to female ratios approaching equality are found in some private clinics, whereas 3:1 or 5:1 ratios are more characteristic of voluntary and public programs. Specialized treatment facilities such as those for drinking drivers or public inebriates often register ratios of 9:1 or 10:1. Household surveys present yet a different picture, as do studies of adolescents. It is sufficient for us at this point to know there are female alcoholics among us in all walks of life, all ethnic and all socioeconomic groups. Many of them are hidden drinkers; all of them destroying their own lives and the lives of those they love. Since alcoholics can and do recover, it is our duty and our privilege to assist these women in a manner most appropriate to the individual needs of each.

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COMMUNITY SERVICES

WOMEN AND ALCOHOLISM: NCA POSITION STATEMENT

NCA is committed to redress past neglect or public ignorance of alcoholism as it affects specific population groups. Primary among these is the woman with alcoholism. The conditions set forth below mandate a public statement of NCA's policy with regard to women and alcoholism, recognizing that many of these conditions can apply to men as well. It is hoped that this statement will encourage and support the work of state task forces on women and alcoholism, NCA affiliates and other public and private agencies in the alcoholism field.

NCA's position toward women and alcoholism is based on the premise that: 1) women have needs in prevention, outreach and treatment for alcoholism which differ from those of men; 2) research findings using male subjects cannot be assumed to apply to women; 3) for both men and women, prevention, outreach and treatment efforts must take into account the familial and societal context of the person with alcoholism; and 4) the disease of alcoholism must be addressed in the context of the overall physical and psychological health of the individual.

All persons with alcoholism and their families bear the burden of moral stigma which society attaches to this disease, but condemnation of the woman with alcoholism is unduly harsh. The woman who drinks to excess is seen as morally deficient, promiscuous and an object of scorn, rather than the victim of a disease. This double standard has had a profound effect on the ability of the woman with alcoholism to seek help for her illness, or to be helped by those close to her.

The physiological, psychological and social aspects of alcoholism in women are still not fully understood, although recent research has revealed significant differences between male and female alcoholism: women tend to develop alcoholism later in life, with a more rapid progression of the disease, and they appear to be more prone to certain physiological consequences, such as cirrhosis of the liver. There are also indications that women respond differently to intervention and treatment approaches than do men. Little hard data exists on the relative effectiveness of particular treatment modalities for women. Research on female alcoholism was virtually ignored until recent years and is still in its infancy. The pattern of alcoholism in special female populations--the elderly, youth, minority women, etc.--is still unexplored.

Social stereotypes of women have led to discrimination in all areas of life, including prejudicial or inappropriate treatment for health problems. These attitudes, often internalized by women themselves, place a heavy burden on the women suffering from alcoholism. Women typically have sought treat-

ment at a later stage in their illness than men, and have been viewed by treatment professionals as more pathological than men and more difficult to treat. These assumptions have implications for the kinds of treatment most suited to alcoholic women and the need for special supportive services for women. In addition, the changes in women's roles are affecting millions of women and engendering new stresses. This further complicates approaches to reaching and treating women with alcoholism, since younger women and women adopting new roles may require different treatment and support systems than older or more traditionally oriented women.

Both men and women in treatment for alcoholism benefit from the availability of supportive services such as vocational rehabilitation, and financial and legal counseling. For women, this need is particularly acute. Many women have had little training, experience, or encouragement in leading lives of self-sufficiency. For the alcoholic women, the lack of life skills can be a major barrier to recovery, especially for those who live alone or who are the sole support of their children. Additional support services are needed by women with special needs, such as lesbians, minority women, older women and the handicapped.

Health professionals are often ill-equipped to diagnose alcoholism and to recommend proper treatment for the illness. This lack of knowledge may be further compounded by stereotypical attitudes toward women. Psychiatrists and other physicians are insufficiently aware of the dangers of cross-tolerance between alcohol and other drugs. Women are particularly vulnerable in this area, since they receive annually two-thirds of the prescriptions for mood-altering drugs. Obstetricians and gynecologists have particular need for information about alcoholic symptoms, due to the high correlation between alcoholism and ob/gyn problems.

The lack of adequate child care facilities for the woman with alcoholism with children must be viewed as a serious deficiency and a frequent barrier to seeking treatment.

IN VIEW OF THESE CONDITIONS, THE NATIONAL COUNCIL ON ALCOHOLISM ADVOCATES THE FOLLOWING POLICIES AND ACTIONS WITH REGARD TO WOMEN AND ALCOHOLISM:

1. That agencies providing treatment for women with alcoholism be encouraged to provide for ADEQUATE CHILD CARE FACILITIES; that accreditation bodies give consideration to child care facilities in

their assessment of treatment programs; that NCA member organizations and task forces on women and alcoholism assist local treatment agencies in creating child care networks, utilizing such existing resources as Foster Grandparents, day care centers and child welfare associations and seeking new ones.

2. That the NATIONAL COMMISSION ON ALCOHOLISM AND ALCOHOL RELATED PROBLEMS, mandated by Public Law 96-180, be immediately appointed; that its membership include appropriate representation of women, with particular attention to minority women; and that among its charges be to study: a) the quality and appropriateness of current treatment programs serving women; b) the dollar amounts provide for research on women and alcoholism; and c) the availability, quality and appropriateness of current treatment programs serving minority women.

3. That the PRESIDENT'S INTERDEPARTMENTAL TASK FORCE ON DOMESTIC VIOLENCE be required to publish a report on the relationship of alcohol and alcoholism to violence in the family.

4. That the DEPARTMENTS OF HOUSING AND URBAN DEVELOPMENT, AGRICULTURE AND LABOR, AND THE LAW ENFORCEMENT ASSISTANCE ADMINISTRATION develop outreach and educational programs for women affected by alcoholism and alcohol abuse.

5. That the LAW ENFORCEMENT ASSISTANCE ADMINISTRATION AND THE DEPARTMENT OF HEALTH AND HUMAN RESOURCES require all grantees for programs treating alcohol-related problems such as rape, wife-battering and child abuse to collect data on alcohol use, misuse and alcoholism.

6. That the JOINT COMMISSION FOR THE ACCREDITATION OF HOSPITALS include in its criteria for hospital accreditation, training in identification and diag-

nosis of female alcoholism for hospital personnel, including emergency room personnel, nursing personnel and physicians.

7. That the American Medical Society on Alcoholism (AMSA) and the Research Society on Alcoholism (RSA) join with state task forces on women and alcoholism and NCA affiliates in a STATE-BY-STATE EDUCATIONAL EFFORT directed to medical professionals.

8. That the American Medical Association and County Medical Societies be encouraged to include COURSES ON WOMEN AND ALCOHOLISM in conferences and workshops which offer CME units.

9. That the National Board of Medical Examiners and all other medical licensing boards be encouraged to include questions on female alcoholism and the interaction of prescription drugs and alcohol in all LICENSING EXAMINATIONS.

10. That POLICE ACADEMIES be encouraged to offer courses on alcoholism and its relationship to crimes of violence such as rape, wife-battering and child abuse.

11. That the national offices of MAJOR RELIGIOUS DENOMINATIONS be urged to recognize alcoholism in women as a treatable disease, to educate their parishioners, and provide training for clergy personnel in counseling and referral of women with alcohol problems.

12. That the National Association of Social Workers, the American Psychiatric Association, the American Psychological Association, the National Nursing Association, the American Academy of Family Practice and other PROFESSIONAL ASSOCIATIONS be encouraged to include workshops on female alcoholism and cross-addiction in conferences sponsored for their memberships and provide information on these subjects in their professional journals or newsletters.

13. That WOMEN'S ORGANIZATIONS, especially those concerned with women's health, be encouraged to recognize alcoholism as a major health problem among women and to disseminate information on alcoholism to their membership on an ongoing basis.

14. That INDUSTRIAL ALCOHOLISM PROGRAMS be encouraged to explore outreach and intervention strategies designed for female employees; that occupational programs actively recruit and hire more women for both leadership and counseling positions.

15. That MORE WOMEN BE RECRUITED AND HIRED for positions of authority in the alcoholism field, in local, state and federal government, and in private industry.

16. That statewide voluntary organizations take the lead in encouraging and working with regulatory agencies to establish STANDARDS OF ETHICAL PRACTICE for intervention and treatment programs.

Senator HAWKINS. Thank you so much; very interesting.

Mr. Kirkpatrick, could you tell me how you feel the Federal Government could best assist you with your efforts at the State level?

Mr. KIRKPATRICK. Well, I think that some of them have been outlined by this panel very nicely. The first would be in trying to assist us with collecting data across the country. What is the extent of the alcohol and drug problem nationwide? What are the characteristics of the people who have that problem? What is being done with those people in our treatment programs? What are effective prevention programs, and how can you measure them and how can you replicate them? What are the most effective and suitable means of treatment, and how have they been demonstrated, as such?

All of these things need national leadership and national input, as does the translation of what is pure research into something that is useful and practical to the people who are trying to prevent and treat alcoholism and drug dependency right now; not just in terms of the research money that can be put into applied research, but in terms of special money for demonstrations to show and establish models that all three speakers here today have identified as a great need. It is in those areas.

There is a paradox here for the Institutes in that their role has been cut back dramatically from when they funded services and prevention into a pure research effort. Nevertheless, they are called upon to provide the national perspective and to exercise leadership at the national level.

They can only do this if they have a national data system, which they have to develop with the States, and if they are willing to take that leadership role in terms of demonstrating what is useful and what is not and in terms of setting money aside for that purpose.

Senator HAWKINS. Has the implementation of the Alcohol, Drug Abuse and Mental Health Administration [ADAMHA] block grant gone smoothly at the State level?

Mr. KIRKPATRICK. It has gone smoothly from an administrative standpoint in that most States were already administering most of the categorical grants previously through the State agencies.

Financially, however, it represented a serious cutback in the amount of money available to the States. Our own calculations, building in the reduction directly in funds as well as the cost-of-living increases that are reflected in what it costs to provide the services, resulted in a net of about a 42-percent decrease in support. That is a problem.

Through a survey process we are currently collecting data from all of our members on the impact of the financial cutback accompanying the block grant. I think you will see that there has been a remarkable impact. We have programs that are way overutilized—waiting lists for treatment in nearly every State.

There is, in my view, an unprecedented public awareness of alcohol and drug problems at the present time, and an unprecedented demand that something be done. Unfortunately, the resources to meet that demand have not been commensurate with it.

In my own State of Illinois and in other big States like New York, the demand for treatment and prevention services is overwhelming. And yet those are sometimes the hardest to sell and to justify because the research has not been done to prove which ones are effective. Documenting their effectiveness is a role which the national institutes can play a major role.

Senator HAWKINS. At a drug hearing we held in New York last year, one of the professionals suggested that NIDA probably would be the best one that could develop a mobile type of education tool to go from school to school. It was discussed with the director of education for the State of New York and he enthusiastically supported that because he was having a great problem getting each school to have a program.

New York is a big State and has to get by and watch its money carefully.

Mr. KIRKPATRICK. Working with the schools probably holds the greatest promise for doing a lot with young people today, if you start early enough, and by that I mean at 8, 9, and 10 years old. But the money available to education, as you know, is always a critical issue and they do not want to spend any money on it.

So, again, it falls back on the people who are in the business of providing the prevention and treatment services to do it. I think NIDA could be very useful in providing us assistance to do that, and we have the philosophy in Illinois—and I know you have met our lieutenant governor and talked about some of the programs that he was interested in through the Lieutenant Governors Association.

We find that the most effective prevention programs are those which are what I would call the grassroots; that is, they originate from the ground up, rather than trying to impose a program on a community or a school from the top. They have to participate in developing it and running it so that they feel that it is adapted to their own particular situation.

Senator HAWKINS. Thank you.

Ms. Pasternak, you mentioned in your testimony today that the National Institute of Mental Health has announced a request for

bids for a grant contract to develop DRG's for the prospective payment system under medicare for general hospital pscychiatric units and hospitals.

Could you elaborate on that NIMH proposal and the impact you feel it may have on NIAAA?

Ms. PASTERNAK. Let me first start by saying that I think the impact on NIAAA is far less than it would be on the alcoholism treatment field. What we are certainly supporting is that NIAAA have an active voice in the NIMH process of DRG determination for alcoholism.

It is our understanding that contracts are to be let in May or June, and without appropriate input from NIAAA we feel that the DRG determination for alcoholism could suffer.

Senator HAWKINS. Alcoholism treatment hospitals and units have temporary exclusion from the medicare prospective payment system.

Ms. PASTERNAK. Correct, until October 1985.

Senator HAWKINS. Would you please elaborate on the exclusion and why you, as the representative of the private sector treatment industry, believe that the DRG issue is so important to you, your members and the medicare program?

Ms. PASTERNAK. Certainly. First, let me start off by saying that I think the strategic challenge of DRG is to provide cost-efficient treatment and one that is, while it is cost efficient, also cost effective and successful.

The DRG determination of 8.1 days that was initially provided is not representative of the current average length of stay in alcoholism treatment facilities. It would provide a severe handicap to the treatment field to be limited to that number.

More important is the issue of the statistics must reflect in actuality the alcoholism treatment length of stay.

Senator HAWKINS. There are currently no private sector treatment representatives on the NIAAA Advisory Council, as you mentioned in your testimony.

Ms. PASTERNAK. That is correct.

Senator HAWKINS. Why do you think that such representation is necessary and appropriate?

Ms. PASTERNAK. The National Institute on Alcohol Abuse and Alcoholism is that—national. To leave out an important arm of the treatment provider sector, the private sector, is a disservice, we believe, to the policymaking and the policy determination efforts of NIAAA.

I think that there has been much discussion about what is treatment success, and without appropriate input from the private sector—we have valid data and we also have statistics that we think can contribute to a bigger picture of the national issue of alcoholism.

Senator HAWKINS. Do you see any role for NIAAA, which of course is the lead Federal agency for alcoholism, in advising the Office of Personnel Management, which is a sister Federal agency, on the scope of alcoholism treatment coverage under the Federal employees health benefits program?

Ms. PASTERNAK. I see that that role is critical for NIAAA as a focal force in the Federal Government on issues related to alcohol-

ism treatment. For OPM then to turn around and eliminate the benefit of alcholism treatment is a contradiction in policy.

We feel very forcefully that NIAAA can have an active, determinant role in policy for treatment and reimbursement.

Senator HAWKINS. As you may be aware, I have a personal conviction on all the questions. I am just trying to get moral support.

Dr. Blume, what causes addictive behavior?

Dr. BLUME. That is a nice question and I wish I could answer it.

Senator HAWKINS. Would you like to answer it for the record?

Dr. BLUME. In the field of alcoholism, we can distinguish at least two kinds of alcohol problems in individuals. One, as Dr. Niven said, is the disease alcoholism which, thanks to NIAAA's research support, has now been shown to have a genetic predisposition and is influenced by cultural factors, ethnic factors and the experience of an individual, like other genetic diseases—diabetes, heart disease—that are similar in that way.

There is another set of alcohol problem drinking behaviors that have to do with social pressures, being expected to drink more than your body will tolerate in order to belong to a certain subgroup or peer group among adolescents; drinking unwisely or drinking in settings that are followed by driving or operating a boat or an airplane or swimming. So many of the drownings have to do with alcoholism.

So we have to look at the wide range of alcohol-related behaviors that cause problems. The addiction is basically the disease alcoholism, and the others are also quite important. NCA is concerned with all of them.

Senator HAWKINS. Are there treatment methods that differ depending on whether a person is addicted to alcohol or addicted to drugs?

Dr. BLUME. The treatment systems as they have grown up have varied a lot with region, as Tom knows. New York State, where I have the most experience—the alcohol treatment and the drug abuse treatment have been separated mainly because heroin was the major drug of abuse.

However, all of us who treat alcoholics treat people who have other dependencies on other drugs as well, and anyone who treats drug abusers treats people with alcohol problems as well. I think we do our very best when we coordinate ourselves and when we do what we know best and do best.

Senator HAWKINS. When does someone become ready for treatment?

Dr. BLUME. The Alcoholics Anonymous Program has an old phrase that they used to use called hitting the bottom, and that people would spontaneously reach a stage when they felt they could not go on; they could not turn back and they would crawl at the bottom and ask for help.

Over the last 10 or 15 years, techniques have been discovered that can kind of produce that bottom, raise that bottom. If you look at Betty Ford's autobiography, you will find that she had an intervention done with her by her family and the people who loved her best, who had been trained on how to face her with her problems.

So instead of waiting for a natural hitting of bottom, we now know ways that can bring people face to face with their problems

at a much earlier stage. That kind of intervention must be followed by treatment. It is worse than nothing to do it if we cannot follow up with treatment because then the expectation is there and the failure is there, too.

Senator HAWKINS. In treating men and women, do the programs differ? Do you use the same programs for a woman addict as you do a male addict?

Dr. BLUME. I have a lot of personal experience with that because I started in 1962 with the first alcoholism treatment unit in the State system in New York, and then in 1965 we started the first women's service. We ran them separately and then I combined them in 1972 and ran them together.

I feel that the importance is not so much where the person is treated, but the sensitivity and the appropriateness of the programming. When the women's issues are understood and when they are part of helping a woman come back into society, the setting is less important.

However, the halfway house level is probably the place where separate facilities for men and women make the most sense because it is a longer-term living arrangement and we have seen success with that model.

The main thrust we have at NCA is to get treatment available to everybody who needs it and we are less concerned with the niceties of setting than an appropriate, caring, informed treatment system.

Senator HAWKINS. In studying and drafting the legislation which provides for a separate women's program, I came across a statistic that you may be the only one who can verify for me that when alcoholism affects a marriage, 1 in 10 husbands stay with an alcoholic wife, while 9 in 10 wives stay with an alcoholic husband. Have you heard that before?

Dr. BLUME. Yes, I have. It came out of a single study. The point that Tom made before is a very good one that sometimes a single population of 100 or 200 cases, when it is the only data we have, is brought out to represent the entire country.

I think later studies have shown different number distributions, but it is quite true that women, for plain economic reasons, find it much harder, especially if they have dependent children, to separate even from an abusive and really bad situation than a man does, who can separate more easily. He usually has more economic earning power than the woman. So that is true.

The Al-Anon family groups which have spouses and family members of alcoholics have been finding more and more men coming in who are living with alcoholic wives now recovering. So I think both are there.

Senator HAWKINS. Thank you all very much. The other Senators, of course, are in other hearings, but are very interested in this hearing. I can reassure you that the fight is on and that we are battling back to protect families from the ravages of alcohol and drug abuse. But without the work of NIDA and NIAAA, I think we are like a blindfolded boxer.

They tell us just what it is that we are fighting against, how big the enemy is, where the enemy will strike next, and why. NIDA and NIAAA, along with all of the fine organizations represented here today, are striving not only to save the minds and lives of our

children, but in my opinion to help keep families safe from those destructive forces that come when we least expect them and prey on our personal weaknesses.

You are to be commended for keeping our eyes open. For that, you should be very proud and I thank you very much. With that, we will adjourn. Thank you.

[Whereupon, at 3:59 p.m., the subcommittee was adjourned.]

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